EDS INDIANA HEALTH COVERAGE PROGRAMS

Tables Manual

Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	June 2000	Multiple	Package C updates	Deanna Daeger
Version 2.0	Dec. 2000	Multiple	2000 Updates	Kari Clendenen
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Version 3.0	August 2002	All	Updated for double-sided printing and updates to section 3 for CSR IN014004	Karen Girgis

Table of Contents

Section 1: Introduction

Overview

The *Tables Manual* contains informational tables used by Indiana*AIM* for claims processing, member eligibility, provider eligibility, financial transactions, and reference file maintenance. Each section in the manual represents one informational table. The tables have been given a common english name and this name has been used for the name of the section in which the table appears. The sections are listed alphabetically by section title. The name of the database table in Indiana*AIM* is listed at the beginning of each section. This is followed by a brief description of the table and its reason for use in Indiana*AIM*. The last portion of each section lists all of the values currently found on the table described in the section.

Section 2: Age Restriction

T_AGE_RESTRICT Table

PURPOSE

Indicates the age range of patients that a primary care physician in the Hoosier Healthwise program will accept. This data is used in auto-assignment to ensure patients are placed with appropriate doctors and is also provided to members who selected a primary medical provider (PMP).

Table 2.1 – T_AGE_RESTRICT

Age Restriction Code	Description	Minimum Age	Maximum Age
AA	NO AGE RESTRICTIONS	0	999
BB	0 – 12 YEARS OF AGE	0	12
CC	13 – 20 YEARS OF AGE	13	20
DD	AGE 21 AND OVER	21	999
EE	0 – 20 YEARS OF AGE	0	20
FF	AGE 13 AND OVER	13	999
GG	0 – 2 YEARS OF AGE	0	2
HH	0 – 17 YEARS OF AGE	0	17
II	13 – 17 YEARS OF AGE	13	17
JJ	AGE 3 AND OVER	3	999
KK	AGE 17 AND OVER	17	999

Section 3: Aid Category

T_CDE_AID Table

PURPOSE

Lists the valid Indiana Health Coverage Programs (IHCP) aid categories that are transmitted from the Indiana Client Eligibility System to Indiana*AIM*.

Table 3.1 – T_CDE_AID

AID Category	Description	Buy-In Eligible	Dual Aid Eligible	Managed Care Eligible	Disable Eligible
1	Children age < 19 who meet TANF income stds		N	Y	N
1P	Refugee children age<19 who meet TANF income stds		N	N	N
2	Children ages 6-19 under 100% FPL		N	Y	N
2P	Refugee children ages 6-19 under 100% FPL		N	N	N
3	Wards not IVE eligible under 18		N	Y	N
3P	Refugee wards not IVE eligible under 18		N	N	N
4	Title IVE foster children under 18		N	Y	N
4P	Refugee Title IVE foster children under 18		N	N	N
5	ARCH for Aged		N	N	N
5P	ARCH for Aged, refugee		N	N	N
6	ARCH for Blind		N	N	N
6P	ARCH for blind, refugee		N	N	N
7	ARCH for disabled		N	N	N
7P	ARCH for disabled, refugee		N	N	N
8	Children Receiving Adoption Assistance		N	N	N
8P	Refugee Children Receiving Adoption Assistance		N	N	N
9	Children age 1-19 up to 150% poverty (CHIP I)		N	Y	N
10	Hoosier Healthwise-Package C-Childrens Health Plan	N	N	Y	N
12	BCCTS Breast / Cervical Cancer Treatment Services	N	N	N	N
59	temp aid cat for 590	N	N	N	N
A	Aged		N	N	N

Table 3.1 – T_CDE_AID

AID Category	Description	Buy-In Eligible	Dual Aid Eligible	Managed Care Eligible	Disable Eligible
AP	Aged, refugee		N	N	N
B	Blind		N	N	N
BP	Blind, refugee		N	N	N
C	Low Income Families		N	Y	N
CP	Refugee Low Income Families		N	N	N
D	Disabled		N	N	N
DI	Working Disabled MEDWORKS Improved		N	N	N
DP	Disabled, refugee		N	N	N
DW	Working Disabled MEDWORKS		N	N	N
E	Extended Eligibility for Pregnant Women		N	Y	N
F	Transitional Medical Assistance		N	Y	N
FP	Refugee Transitional Medical Assistance		N	N	N
G	Qualified Disabled Working Individual (QDWI)	Y	N	N	N
GP	Refugee Qualified Disabled Working Individual QDWI	Y	N	N	N
H	Ineligible for AFDC due to deemed income		N	Y	N
HP	Refugee ineligible for AFDC due to deemed income		N	N	N
I	Qualified Individual - 1		N	N	N
J	Special Low Income Medicare Beneficiary (SLMB)		Y	N	N
K	Qualified Individual - 2		N	N	N
L	Qualified Medicare Beneficiary (QMB)	Y	Y	N	N
LP	Refugee Qualified Medicare Beneficiary (QMB)	Y	Y	N	N
M	Pregnancy - Full Coverage		N	Y	N
MP	Refugee Pregnancy - Full Coverage		N	N	N
N	Pregnancy - Related Coverage		N	Y	N
NP	Refugee Pregnancy - Related Coverage		N	N	N
O	Children < 21 in inpatient psych facility		N	N	N
OP	Refugee children <21 in inpatient psych facility		N	N	N
P	No longer used		N	N	N
PP	No longer used		N	N	N
Q	Refugee Medical Assistance (RMA)		N	N	N
R	Room and Board Assistance (RBA)		N	N	N

Table 3.1 – T_CDE_AID

AID Category	Description	Buy-In Eligible	Dual Aid Eligible	Managed Care Eligible	Disable Eligible
RP	Refugee Room and Board (RBA)		N	N	N
S	Ineligible for AFDC due to sibling income		N	Y	N
SP	Refugee ineligible for AFDC due to sibling income		N	N	N
T	Children age18,19,20 living w/specified relative		N	Y	N
TP	Refugee child age 18,19,20 w/specified relative		N	N	N
U	Ineligible for TANF due to SSI payments		N	Y	N
UP	Refugee ineligible for TANF due to SSI payments		N	N	N
X	Newborn - infants born to Medicaid recipients		N	Y	N
XP	Newborn - infants born to refugee recipients		N	N	N
Y	Children age<1 under 150% FPL		N	Y	N
YP	Refugee children age < 1 under 150% FPL		N	N	N
Z	Children ages 1-5 under 133% FPL		N	Y	N
ZP	Refugee children ages 1-5 under 133% FPL		N	N	N

Section 4: ASC Group

T_ASC_GROUP Table

PURPOSE

Indicates the different Abulatory Surgical Center (ASC) groups to which a procedure can be assigned pricing.

Table 4.1 – T_ASC_GROUP

ASC Code	Description
1	This is the description for ASC 0
2	This is the description for ASC 0
3	This is the description for ASC 0
4	This is the description for ASC 0
5	This is the description for ASC 0
6	This is the description for ASC 0
7	This is the description for ASC 0
8	This is the description for ASC 0
9	This is the description for ASC 0
A	This is the description for ASC A
B	This is the description for ASC B
C	This is the description for ASC C
D	This is the description for ASC D
E	This is the description for ASC E
F	This is the description for ASC F
G	Inpatient Only
N	Non-Covered Service

Section 5: Assignment Code

T_PA_ASSIGN_CODE Table

PURPOSE

Indicates into what grouping a PA falls. This information is used to track, analize, and to categorize workflows.

Table 5.1 – T_PA_ASSIGN_CODE

PA Code	Description	Group Code Assigned
01	HOMEHEALTH	01
02	HOSPITAL	02
03	OUTPATIENT	02
04	PHYSICIAN	03
05	REHAB	10
06	TRANSPLANT	10
07	TRANS	04
08	AUDIOLOGY	06
09	SPEECH	06
10	MENTAL HS	05
11	DME	10
12	OT	06
13	PT	06
14	RT	06
15	DENTAL	07
16	OD	03
17	PODIATRY	03
18	CHIRO	08
19	PHAR	09

Section 6: Average Expenditure

T_AVERAGE_EXPEND Table

PURPOSE

This data represents the average expenditures for a given aid category, sex, and age combination. The data is used to determine cost effectiveness in the Health Insurance Premium Payment (HIPP) program. If the member's private health insurance cost is less than the average IHCP expenditure, then it is generally cost effective to enroll the member in private insurance and pay the premium.

Table 6.1 – T_AVERAGE_EXPEND

Aid Category	Sex	Beginning of Age Range	End of Age Range	Average Annual Expenditure
Blind	F	0	5	7436.64
Blind	F	6	12	604.81
Blind	M	6	12	1238.44
Blind	F	13	20	1610.85
Blind	M	13	20	5156.26
Blind	F	21	48	3745.04
Blind	M	21	48	4907.6
Blind	F	49	64	7325.45
Blind	M	49	64	5907.14
Disabled	F	0	5	15123.93
Disabled	M	0	5	11684.79
Disabled	F	6	12	7581.05
Disabled	M	6	12	8854.43
Disabled	F	13	20	7132.09
Disabled	M	13	20	7597.48
Disabled	F	21	48	8330.04
Disabled	M	21	48	8457.13
Disabled	F	49	64	8811.45
Disabled	M	49	64	8776.21

Section 7: Batch Error Messages

T_BATCH_ERR_MSG Table

PURPOSE

This is a listing of all of the error codes that may be produced during the ICES update to *AIM*. An error message can result in the rejection of the entire record (REJECT), the segment (REJECT SEG), the field (REJECT FLD), a warning message (WARNING), the zeroing out of data (FLD ZEROED), or the non-issuance of an ID card (NO CARD). This data is provided back to ICES so that errors can be corrected.

Table 7.1 – T_BATCH_ERR_MSG

Error Code	Description of Error Message	Action Taken
55	CARRIER NOT FOUND ON CARRIER FILE	REJECT REC
56	MEDICARE CARRIER	REJECT REC
66	TXN COV CODE COUNT <> TO TPL COV CODE COUNT	REJECT
67	TXN COV CODES <> TPL RESOURCE COV CODES	REJECT
95	HMS MEDICAID ID DOES NOT EQUAL ELIGIBILITY ID	REJECT REC
96	RECIPIENT NOT FOUND ON ELIGIBILITY	REJECT REC
100	BAD RESOURCE INFO FROM HMS	REJECT REC
115	HMS COVERAGE CODE INVALID	REJECT
116	HMS RELATIONSHIP CODE INVALID	REJECT
125	POLICY HOLDER LAST NAME IS SPACES	REJECT POL INFO
470	HMS DID NOT SEND ALL COV CODES FOR RESOURCE	REJECT
471	COV CODE DATES VARY - RESEARCH MUST BE PERFORMED	REJECT
475	MORE THAN 10 COV CODES FOR THIS RESOURCE	REJECT
550	HMS RECIP NOT FOUND	REJECT
556	HMS PROVIDER ID NOT FOUND	REJECT
560	HMS CLAIM NOT FOUND	REJECT
570	HMS A/R NUMBER INVALID	REJECT
571	HMS A/R DOES NOT START WITH 63	REJECT
580	CARRIER INFO INVALID	REJECT
600	HMS DATE BILLED INVALID	INFO

Table 7.1 – T_BATCH_ERR_MSG

Error Code	Description of Error Message	Action Taken
625	HMS TRANSTAT CODE INVALID	INFO
630	HMS ATTEMPTS TO UPDATE CLOSED A/R	REJECT
640	HMS CCN NOT FOUND	REJECT
645	CCN HAS ALREADY BEEN DISPOSITIONED FULLY	REJECT
650	HMS REMIT AMOUNT IS ZEROES	REJECT
651	HMS REMIT AMOUNT IS MORE THAN THE CCN BALANCE	INFO
652	CCN BALANCE GREATER THAN ZERO	INFO
653	HMS REMIT AMOUNT > A/R AMOUNT	INFO
655	HMS REMIT DATE INVALID	INFO
690	HMS POL HOLDER SSN INVALID	INFO
691	HMS POL HOLD SSN NOT FOUND	INFO
1400	CSHCS CASE STATUS CODE IS MISSING OR INVALID	REJECT
1403	ADDRESS STREET 1 IS MISSING	REJECT
1450	RECIPIENT MOTHER RID DOES NOT EXIST	REJECT
1456	RECIPIENT MOTHER RID DOES NOT EXIST	REJECT
1460	ACTUAL REDETERMINATION DATE INVALID	REJECT
1462	PLANNED REDETERMINATION DATE INVALID	REJECT
1500	CSHCS CASE STATUS CODE IS MISSING OR INVALID	REJECT SEG
2000	RECIPIENT ID EXISTS BUT INACTIVE(PURGED)	REJECT
2001	RECIPIENT ID DOES NOT EXIST	REJECT
2002	RECIPIENT ID REQUIRED	REJECT
2003	RECIPIENT FIRST AND LAST NAME REQUIRED FOR ADD	REJECT
2004	DATE OF BIRTH IS INVALID DATE	REJECT
2005	MCPD: INVALID PHONE NUMBER (NOT NUMERIC)	REJECT FLD
2006	DATE OF BIRTH CANNOT BE GREATER THAN CURRENT DATE	REJECT
2007	SEX CODE IS REQUIRED FOR ADD	REJECT
2008	POSSIBLE(SUSPECT) DUPLICATE RECIPIENT	REJECT
2009	DATE OF DEATH CANNOT BE LESS THAN DATE OF BIRTH	REJECT FLD
2010	ADDRESS STREET 1 IS MISSING	SPACE FLD
2012	CITY ADDRESS IS MISSING	SPACE FLD

Table 7.1 – T_BATCH_ERR_MSG

Error Code	Description of Error Message	Action Taken
2013	STATE ADDRESS IS MISSING	SPACE FLD
2014	STATE ADDRESS IS INVALID	SPACE FLD
2015	ZIP 5 IS MISSING OR NON-NUMERIC	SPACE FLD
2016	ZIP 4 MUST BE NUMERIC	REJECT FLD
2018	RACE CODE IS MISSING OR INVALID	REJECT FLD
2019	COUNTY CODE IS INVALID	REJECT FLD
2020	DATE OF DEATH IS INVALID DATE	REJECT FLD
2022	DATE OF DEATH CANNOT BE GREATER THAN CURRENT DATE	REJECT FLD
2025	SSN IS MISSING OR NON-NUMERIC	FLD ZEROED
2026	SSN EXISTS FOR ANOTHER RECIPIENT	FLD ZEROED
2031	DATE OF BIRTH CANNOT BE GREATER THAN CURRENT DATE	REJECT FLD
2032	SEX CODE IS INVALID	REJECT FLD
2033	MARITAL STATUS CODE IS INVALID	REJECT FLD
2034	PRIMARY LANGUAGE CODE IS INVALID	REJECT FLD
2037	CASE NUMBER IS MISSING OR NON NUMERIC	REJECT FLD
2041	FAMILY QUANTITY IS NON NUMERIC	REJECT FLD
2044	ID CARD ISSUE REASON CODE IS INVALID	NO CARD
2046	COUNTY CODE WARD IS MISSING OR INVALID	REJECT FLD
2047	WARD TYPE IS MISSING OR INVALID	REJECT FLD
2055	LINK: OLD RECIPIENT ID REQUIRED	REJECT
2060	LINK: RID EXISTS, OLD RID NOT FOUND	REJECT
2062	LINK: RID NOT FOUND, OLD RID NOT FOUND	REJECT
2063	LINK: RID NOT FOUND, OLD RID INACTIVE	REJECT
2076	UNLINK: RID DOES NOT EXIST ON BASE	REJECT
2077	UNLINK: OLD RECIPIENT ID REQUIRED	REJECT
2078	UNLINK: OLD RID ALREADY EXISTS ON BASE	REJECT
2082	UNLINK: RECIPIENTS NOT PREVIOUSLY LINKED	REJECT
2090	UNLINK: RECIPIENT NOT PREVIOUSLY CHANGED	REJECT
2100	MCPD: INVALID MRT STATUS CODE	REJECT FLD
2101	MCPD: INVALID/MISSING DIAGNOSIS CODE(S)	REJECT FLD
2102	MCPD: PRESENT/FUTURE MRT STATUS ALREADY	REJECT FLD

Table 7.1 – T_BATCH_ERR_MSG

Error Code	Description of Error Message	Action Taken
	EXISTS	
2200	EFFECTIVE DATE IS MISSING OR INVALID	REJECT SEG
2201	ELIGIBILITY PROGRAM MISSING OR INVALID	REJECT SEG
2202	ELIGIBILITY AID CATEGORY MISSING OR INVALID	REJECT SEG
2203	END DATE IS MISSING OR INVALID	REJECT SEG
2205	EFFECTIVE DATE CANNOT BE GREATER THAN END DATE	REJECT SEG
2207	EFFECTIVE DATE CANNOT BE LESS THAN DATE OF BIRTH	REJECT SEG
2208	END DATE CANNOT BE GREATER THAN DATE OF DEATH	REJECT SEG
2209	OVERLAPPING ELIGIBILITY SEGMENTS	REJECT SEG
2210	MUST HAVE AT LEAST 1 GOOD SEGMENT	REJECT
2250	NAME DOES NOT MATCH EXISTING RECIPIENT NAME	REJECT
2257	ELIGIBILITY PROGRAM CANNOT OVERLAP 590 PROGRAM	REJECT SEG
2502	SPEND MET DATE IS INVALID DATE	REJECT FLD
2504	NO SPENDDOWN PERIOD EXISTS FOR THIS SPEND MET DT	REJECT FLD
2602	INVALID HIB	REJECT FLD
2604	NO HIB AND RECIPIENT AGE IS > 64	WARNING
2605	HIB ALREADY EXISTS	REJECT
2701	DUAL AID CATEGORY IS INVALID	REJECT FLD
3001	PROVIDER IS ZEROES OR NON-NUMERIC	REJECT
3002	PROVIDER ID DOES NOT EXIST	REJECT
3003	PROVIDER CARE CODE IS MISSING OR INVALID	REJECT
3004	DATE OF BIRTH IS INVALID DATE	REJECT FLD
3012	CITY ADDRESS IS MISSING	REJECT
3013	STATE ADDRESS IS MISSING	REJECT
3014	STATE ADDRESS IS INVALID	REJECT
3015	ZIP 5 IS MISSING OR NON-NUMERIC	REJECT
3018	RACE CODE IS MISSING OR INVALID	REJECT
3019	COUNTY CODE IS INVALID	REJECT

Table 7.1 – T_BATCH_ERR_MSG

Error Code	Description of Error Message	Action Taken
3200	EFFECTIVE DATE IS MISSING OR INVALID	REJECT
3203	END DATE IS MISSING OR INVALID	REJECT
3205	EFFECTIVE DATE CANNOT BE GREATER THAN END DATE	REJECT
3207	EFFECTIVE DATE CANNOT BE LESS THAN DATE OF BIRTH	REJECT
3208	END DATE CANNOT BE GREATER THAN DATE OF DEATH	REJECT
4000	CARRIER NUMBER NOT FOUND	REJECT SEG
4001	CARRIER NUMBER GREATER THAN 7 BYTES	REJECT SEG
4006	VALID TPL RESOURCE NOT FOUND	REJECT SEG
4116	HIPP RESOURCE EXISTS FOR DELETE RECORD	REJECT DELETE
4202	POLICY NUMBER NOT PRESENT	REJECT FLD
4206	COURT ORDER CODE INVALID	REJECT FLD
4208	RELATIONSHIP CODE INVALID	REJECT FLD
4212	TPL EFFECTIVE DATE INVALID	REJECT SEG
4214	TPL END DATE INVALID	REJECT SEG
4215	TPL END DATE > 3 YEARS	REJECT SEG
4216	TPL EFF ECTIVE DATE > TPL END DATE	REJECT SEG
4230	POLICY HOLDER STATE CODE INVALID	REJECT FLD
4234	ZIP CODE NOT NUMERIC	REJECT FLD
4238	POLICY HOLDER SSN IS NOT NUMERIC	REJECT FLD
4260	INVALID COVERAGE CODE	REJECT FLD
4261	INVALID COVERAGE CODE FOR THIS CARRIER	REJECT FLD
4264	NO COVERAGE CODES PRESENT FOR RESOURCE	REJECT SEG
4304	POLICY HOLDER IS INVALID	REJECT FLD
4306	COVERAGE CODE MUST BE M OR N FOR MEDICARE	REJECT SEGMENT
4323	MEDICARE B COVERAGE OVERLAPS	REJECT SEGMENT
4324		
4330	MEDICARE A COVERAGE OVERLAPS	REJECT SEGMENT
4333	MEDICARE COVERAGE REQUIRES HIB	REJECT MEDICARE
4334	HIB IS A DUPLICATE	REJECT HIB

Table 7.1 – T_BATCH_ERR_MSG

Error Code	Description of Error Message	Action Taken
5901	NO MATCH FOR 590 RECIPIENT	REJECT
5902	590 SEGMENT OVERLAPS EXISTING ELIGIBILITY	REJECT
5903	BAD MANAGED CARE TO AID CATEGORY MATCH	REJECT

Section 8: Billing Media

T_BILLING_MEDIA Table

PURPOSE

Indicates how the provider bills claims to the IHCP.

Table 8.1 – T_BILLING_MEDIA

Code	Description
E	ELECTRONIC
P	PAPER

Section 9: Birth Weight

T_BIRTH_WEIGHT Table

PURPOSE

Lists the minimum and maximum birth weights defined in
International Classification of Diseases, 9th Revision (ICD-9) for a
given diagnosis code. This is used during the pricing process to assign
the appropriate DRG to a claim.

Table 9.1 – T_BIRTH_WEIGHT

Diagnosis Code	Minimum Weight	Maximum Weight
76401	0	499
76402	500	749
76403	750	999
76404	1000	1249
76405	1250	1499
76406	1500	1749
76407	1750	1999
76408	2000	2499
76409	2500	2500
76411	0	499
76412	500	749
76413	750	999
76414	1000	1249
76415	1250	1499
76416	1500	1749
76417	1750	1999
76418	2000	2499
76419	2500	2500
76421	0	499
76422	500	749
76423	750	999
76424	1000	1249
76425	1250	1499

Table 9.1 – T_BIRTH_WEIGHT

Diagnosis Code	Minimum Weight	Maximum Weight
76426	1500	1749
76427	1750	1999
76428	2000	2499
76429	2500	2500
76491	0	499
76492	500	749
76493	750	999
76494	1000	1249
76495	1250	1499
76496	1500	1749
76497	1750	1999
76498	2000	2499
76499	2500	2500
76501	0	499
76502	500	749
76503	750	999
76504	1000	1249
76505	1250	1499
76506	1500	1749
76507	1750	1999
76508	2000	2499
76509	2500	2500
76511	0	499
76512	500	749
76513	750	999
76514	1000	1249
76515	1250	1499
76516	1500	1749
76517	1750	1999
76518	2000	2499
76519	2500	2500

Section 10: Buyin Billing TXN Codes

T_CDE_BUY_BILL Table

PURPOSE

List the valid transaction codes for the Buy-In program that may be received on the monthly tape from Health Care Financing Administration (HCFA). On the basis of these codes, distinct actions are taken regarding a member's Buy-In coverage (such as, accretion or deletion).

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
11	64	Not used by Indiana.	A	Z
11	XX	Code 11 informs the State that the indv was accreted to a State Buyin acct which results in a debit action to the State. The State is liable for the indv's Medicare prem and will be billed monthly.	A	Z
11	85	Not used by Indiana.	A	Z
11	80	Not used by Indiana.	A	Z
11	75	Informs the State a simultaneous accretion(1175)/deletion(1776) action was added to the TPM. The deletion date is more than 2 mos prior to the update month.	A	T
11	67	Informs the State that a Public Welfare accretion was processed to the TPM. The State has 4 mos following the month it received notification to request an annulment or termination of the buyin action.	A	P
11	28	Informs the State that the effective date in an accretion submitted by the State was adjusted by the Third Party System to a later date. The TPM showed a closed coverage period for a different State.	A	G
11	65	Informs the State that an accretion was processed to the TPM by HCFA. This occurred because the State submitted a paper document to the TPM	A	O
11	61	Informs the State that the individual was accreted to Buy-In. The effective date is the same as reported except when a code 30 is present.	A	L
11	84	Informs the State that an accretion, which is usually submitted by an alert State in response to a code 86 accretion alert record, has been added to the TPM.	A	V

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
11	72	Informs the State that a closed buy-in coverage period prior to existing coverage was added to the TPM. Code 1172 is always paired with a code 1772 deletion record.	A	S
11	25	Informs the State that the effective date in an accretion submitted by the State was adjusted by the Third Party System to a later date. The TPM showed a closed coverage period for the same State.	A	F
11	90	Not used by Indiana.	A	Z
14		Not used by Indiana.	Z	Z
15		Informs the state that the individual was deleted from State's buy-in account because SSA's records indicate that the individual does not meet all the requirements for Medicare.	B	Z
15	0	Informs the State that the individual was deleted form the States Buy-In account because ssis records indicate that the individual does not currently meet all requirements for Medicare	B	Z
16		Informs the state that according to SSA's records, the individual is dead and has been deleted from the State's buy-in account. To reaccrete, the State must obtain corroboration in writing from SSA.	C	Z
16	0	Informs the State that according to SSAs records, the individual is dead and has been deleted from the States Buy-In account.	C	Z
17	81	Not used by Indiana.	D	Z
17	76	Informs the State that a closed period of buyin coverage has been estblshd as requested by the State. A code 1175 accretion with the related code 1776 deletion is sent.	D	U
17		The code 17 informs the State that the individual was deleted from Medicare which triggers a credit action to the State. The premium ends with the month in which the deletion is effective.	D	Z
17	53	Informs the State that a State submitted deletion action was posted to the TPM. The deletion occurred because the individual is deceased. The effective date must be the month and year of death.	D	J
17	51	Informs the State that a State submitted deletion action was posted to the TPM. The deletion occurred because the individual is no longer a member of the State's Buy-In group.	D	I
17	50	Informs the State that a State submitted deletion action was posted to the TPM. The deletion occurred because the State received notification of a code 1165 accretion.	D	H
17	87	Not used by Indiana.	D	Z

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
17	72	Informs the State that a closed period of buyin coverage, which is prior to existing coverage, was added to the TPM. This is always paired with a code 1172 accretion record.	D	S
17	XX	The code 17 informs the State that the individual was deleted from Medicare which triggers a credit action to the State. The premium ends with the month in which the deletion is effective.	D	Z
17	28	Informs the State that an indv was deleted from the State's buyin account because another State requested that the indv be accreted to its acct or because SSI rcds show a state of residence change.	D	G
17	59	Informs the State that a deletion was processed to the TPM by a clerical action in the PM. This action was prompted by a State submitted paper document or a HCFA-1957 submitted by the SSA.	D	K
18	XX	The code 18 informs the State that although there is no evidence of Medicare entitlement, a claim for Medicare is being developed by Social Security.	E	Z
18	63	Informs the State that an accretion submitted by the State could not be processed because the individual does not have Medicare entitlement. However, entitlement is being developed.	E	N
18	84	Informs the State that an accretion submitted by the State could not be processed because the individual does not have Medicare entitlement. However, entitlement is being developed.	E	V
18	64	Not used by Indiana.	E	Z
18	62	Informs the State that an accretion submitted by the State could not be processed because the individual does not have Medicare entitlement. However, entitlement is being developed.	E	M
18	61	Informs the State that an accretion submitted by the State could not be processed because the individual does not have Medicare entitlement. However, entitlement is being developed.	E	L
19	XX	The code 19 informs the State that the individual's application for Medicare was denied. If the system can determine the earliest future date of entitlement to Medicare, the date will be furnished.	F	Z
19	63	Informs the State that an accretion submitted by the State was rejected because the individual's application for Medicare was denied. Refer to code 19XX for a more detailed explanation.	F	N
19	84	Informs the State that an accretion submitted by the State was rejected because the individual's application for Medicare was denied. Refer to code 19XX for a more detailed explanation.	F	V
19	64	Not used by Indiana.	F	Z

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
19	62	Informs the State that an accretion submitted by the State was rejected because the individual's application for Medicare was denied. Refer to code 19XX for a more detailed explanation.	F	M
19	61	Informs the State that an accretion submitted by the State was rejected because the individual's application for Medicare was denied. Refer to code 19XX for more details.	F	L
20	XX	The code 20 informs the State that a deletion action it submitted was rejected either because there is no record of on-going buy-in coverage under the HIB or jurisdiction rests with another State.	G	Z
20	81	Not used by Indiana.	G	Z
20	76	Informs the State that the deletion portion of a simultaneous accretion/deletion action was rejected because the claim number in the accretion failed to match an HI Master record.	G	U
20	50	Informs the State that a deletion action submitted by the State was rejected because there is no record of buy-in coverage under the HIB number submitted or because another State has jurisdiction.	G	H
20	51	Informs the State that a deletion action submitted by the State was rejected because there is no record of buy-in coverage under the HIB submitted or because another State has jurisdiction.	G	I
20	53	Informs the State that a death deletion submitted by the State was rejected because there is no record of buy-in coverage under the HIB submitted or another State has jurisdiction.	G	J
21	XX	The code 21 informs the State that the attempted accretion cannot be matched to the Health Insurance Master record or to the MBR. Each code 21 contains an alphabetic subcode in position 51.	H	Z
21	63	Informs the State that the submitted accretion action was rejected because the accretion can not be matched to an HI Master record or to the MBR.	H	N
21	84	Informs the State that the submitted accretion action was rejected because the accretion can not be matched to an HI Master record or to the MBR.	H	V
21	61	Informs the State that the submitted accretion action was rejected because the accretion cannot be matched to an HI master record or to the MBR.	H	L
21	75	Informs the State the accretion portion of a simult accretion/deletion action was rejected because the claim number in the accretion can't be matched to an HI Master rcd. Companion code = 76.	H	T

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
21	62	Informs the State that the submitted accretion action was rejected because the accretion can not be matched to an HI Master record or to the MBR.	H	M
21	64	Not used by Indiana.	H	Z
22	XX	Informs the State that an accretion action was rejected because the item doesn't match the HI Master rcd but does match an MBR on which the individual is receiving disability benefits.	I	Z
22	84	Accretion reject code.	I	V
22	64	Not used by Indiana.	I	Z
22	63	Accretion reject code.	I	N
22	62	Accretion reject code.	I	M
22	61	Accretion reject code.	I	L
23	XX	Informs the State that the HIB and/or BIC has been changed. A code 23 may be applied to an accretion, deletion, or State change record or to an ongoing code 41 or code 91 transaction.	J	Z
23	64	Not used by Indiana.	J	Z
23	63	Accretion code HIB change.	J	N
23	75	Accretion code HIB change.	J	T
23	99	Informs the State that the HIB on a State submitted change record was changed to conform to HCFA/SSA master records.	J	X
23	50	Deletion code HIB change.	J	H
23	53	Deletion code HIB change.	J	J
23	81	Not used by Indiana.	J	Z
23	76	Deletion code HIB change.	J	U
23	0	Deletion code HIB change.	J	Y
23	62	Accretion code HIB change.	J	M
23	61	Accretion code HIB change.	J	L
23	51	Deletion code HIB change.	J	I
23		Informs the State that a HIB change was processed to an ongoing buy-in record (code 41 or 91).	J	Y
23	84	Accretion code HIB change.	J	V
24	XX	Informs the State that the submitted accretion or deletion action was rejected because the effective date was in error. An accretion will be rejected if the effective date is beyond the billing month.	K	Z
24	76	Deletion code rejects.	K	U

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
24	61	Accretion reject codes.	K	L
24	63	Accretion reject codes.	K	N
24	53	Deletion code rejects.	K	J
24	51	Deletion code rejects.	K	I
24	50	Deletion code rejects.	K	H
24	75	Accretion reject codes.	K	T
24	84	Accretion reject codes.	K	V
24	64	Not used by Indiana.	K	Z
24	62	Accretion reject codes.	K	M
24	81	Not used by Indiana.	K	Z
25	XX	Informs the State that the accretion or deletion action was rejected because it duplicates a txn previously processed by the Third Party System. The code 25XX reject contains an alphabetic subcode.	L	Z
25	53	Deletion reject codes.	L	J
25	61	Accretion reject codes.	L	L
25	63	Accretion reject codes.	L	N
25	64	Not used by Indiana.	L	Z
25	62	Accretion reject codes.	L	M
25	51	Deletion reject codes.	L	I
25	50	Deletion reject codes.	L	H
25	84	Accretion reject codes.	L	V
25	81	Not used by Indiana.	L	Z
27	XX	Informs the State that the submitted accretion or deletion action was rejected because the txn contained an invalid code (ie. blank, alphabetic, or invalid numeric combination).	M	Z
27	50	Informs the State that the deletion action was rejected because it was not submitted within the 2 month time period allowed or because the buyin accretion did not result from a code 1165 action.	M	H
27	75	Informs the State that a code 75 accretion submitted by the State was rejected because it was not followed by a code 76 deletion.	M	T
27	76	Informs the State that a code 76 deletion submitted by the State was rejected because it was not preceded by a code 75 accretion.	M	U
28	XX	Informs the State that the simultaneous accretion/deletion action was rejected because the period of coverage requested is entirely	N	Z

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
		within a buyin coverage period already established on the TPM.		
28	75	If the requested period of buyin coverage is contained in a prior closed history fld on the TPM, position 51 will contain a 'P'. If the period is in the current history fld, position 51 will be blank.	N	T
28	76	If the requested period of buyin coverage is contained in a prior closed history fld on the TPM, position 51 will contain a 'P'. If the period is in the current history fld, position 51 will be blank.	N	U
29	XX	Informs the State that the accretion or simultaneous accrete/delete was rejected because there is a death deletion on the TPM. Subcode D indicates the State submitted the deletion. 'E' indicates MBR.	O	Z
29	62	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.	O	M
29	61	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.	O	L
29	84	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.	O	V
29	76	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.	O	U
29	75	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.	O	T
29	64	Not used by Indiana.	O	Z
29	63	Informs the State that the accretion or simultaneous accretion/deletion was rejected because there is a death deletion on the TPM record.	O	N
30	XX	Informs the State that the eff. dt in the accretion required adjustment to a later eff. dt to conform with the individual's Medicare entitlement date. The Third Party System will create two records.	P	Z
30	64	Not used by Indiana.	P	Z
30	62	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform to conform with the individual's Medicare entitlement date.	P	M
30	61	Informs the State that the effective date in the submitted	P	L

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
		accretion required adjustment to a later effective date to conform with the individual's Medicare entitlement date.		
30	63	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform with the individual's Medicare entitlement date.	P	N
30	84	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform with the individual's Medicare entitlement date.	P	V
30	75	Informs the State that the effective date in the submitted accretion required adjustment to a later effective date to conform with the individual's Medicare entitlement date.	P	T
31	XX	The accretion or deletion submitted by the State cannot be processed in the month of submittal. This interim reply should be controlled by the State until a definitive response is received from HCFA.	Q	Z
31	63	Informs the State that the definitive reply on a State submitted accretion will be delayed because the claim number in the accretion failed to match a corresponding record on the HI Master record.	Q	N
31	51	Informs the State that the definitive reply on a State submitted deletion will be delayed for one month because the deletion encountered a cross-reference record on the TPM.	Q	I
31	61	Informs the State that the definitive reply on a State submitted accretion will be delayed because the claim number in the accretion failed to match a corresponding record on the HI Master record.	Q	L
31	53	Informs the State that the definitive reply on a State submitted deletion will be delayed for one month because the deletion encountered a cross-reference record on the TPM.	Q	J
31	62	Informs the State that the definitive reply on a State submitted accretion will be delayed because the claim number in the accretion failed to match a corresponding record on the HI Master record.	Q	M
31	50	Informs the State that the definitive reply on a State submitted deletion will be delayed for one month because the deletion encountered a cross-reference rcd on the TPM.	Q	H
31	84	Informs the State that the definitive reply on a State submitted accretion will be delayed because the claim number in the accretion failed to match a corresponding record on the HI Master record.	Q	V

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
31	64	Not used by Indiana.	Q	Z
32	XX	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.	R	Z
32	84	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.	R	V
32	61	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.	R	L
32	76	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.	R	U
32	75	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.	R	T
32	64	Not used by Indiana.	R	Z
32	63	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage in prior to existing coverage in TPM current history.	R	N
32	62	Informs the State that an accretion or a simultaneous accretion/deletion cannot be processed in the month submitted because the requested coverage is prior to existing coverage in TPM current history.	R	M
33	XX	Informs the State that the submitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.	S	Z
33	62	Informs the State that the sumbitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.	S	M
33	63	Informs the State that the submitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.	S	N
33	84	Informs the State that the submitted accretion record was	S	V

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
		rejected because the individual is on the TPM as a code 91 for another State.		
33	64	Not used by Indiana.	S	Z
33	61	Informs the State that the submitted accretion record was rejected because the individual is on the TPM as a code 91 for another State.	S	L
34	XX	Informs the State that the submitted deletion was rejected because the individual is on the TPM as a code 91 for that State.	T	Z
34	50	Informs the State that the submitted deletion was rejected because the individual is on the TPM as a code 91 for that State.	T	H
34	53	Informs the State that the submitted deletion was rejected because the individual is on the TPM as a code 91 for that State.	T	J
34	51	Informs the State that the submitted deletion was rejected because the individual is on the TPM as a code 91 for that State.	T	I
36	62	Informs the State that the accretion in which the HIB and personal characteristics had been verified by the Soc. Security office was rejected because the item didn't match the HI Master rcd or MBR	U	M
41		Informs the State that the individual is on the State's payroll as an ongoing item. The State is responsible for paying the individual's Part B premium and has deletion responsibility.	V	Y
41	0	Informs the State that the individual is on the States rolls as an on-going item.	V	Y
42	XX	Represents a credit adjustment of premium liability for the State. This is a result of adjusting either the buyin accretion eff. date or the deletion eff. date of an existing TPM master record.	W	Z
42	41	Informs the State that there were dupe master rcds on the TPM. At least one of the dupe rcds is a code 41 State jurisdiction item. The credit adjustment is for the period of dupe buyin coverage.	W	A
42	68	Informs the State that the accretion date on a TPM record was ajdusted to a later date resulting in a credit to the State.	W	Q
42	67	The buyin effective date of a "PW" accretion has been adjusted to a later date resulting in a credit to the State.	W	P
42	0	Informs the State that an existing deletion date has been adjusted to an earlier date.	W	Y
42	15	Informs the State that an existing deletion date has been adjusted to an earlier dt because the indv did not meet all the requirements for Medicare and should not have been terminated.	W	D
42	14	Informs the State that an existing deletion date was adjusted to	W	C

Table 10.1 – T_CDE_BUY_BILL

Transaction Code	Transaction Modifier	Description	Alpha Code	Alpha Modifier
		an earlier date. This was due to a HCFA initiated SSI accretion which has higher priority and overrides an existing deletion.		
42	11	Adjustment of the buyin accretion date in an on-going record to a later date. This was necessary because the Third Party Syst. was notified of a condition which changed the indv's Medicare enttlmnt dt	W	B
42		Credit adjustment to the State because the dupe master records were identified. The dupe billing occurred for one or more months of buyin coverage. The dupe premiums are being refunded to the State.	W	Y
42	91	Not used by Indiana.	W	Z
42	69	Informs the State that a deletion date on a TPM record was adjusted to an earlier date resulting in a credit to the State.	W	R
42	16	Informs the State that an existing death deletion date was in error and has been adjusted to an earlier date.	W	E
43	XX	Represents a debit adjustment of premium liability for the State. These actions are the result of adjusting either the accretion eff. date or the deletion eff. date of an existing master on the TPM.	X	Z
43	69	Informs the State that the deletion date on a TPM record was adjusted to a later date resulting in a debit to the State.	X	R
43	0	Represents a debit adjustment of premium liability for the State. These actions are the result of either the accretion eff. date or the deletion eff. date of an existing master on the TPM.	X	Z
43	68	Informs the State that the accretion date on a TPM record was adjusted to an earlier date resulting in a debit to the State.	X	Q
43		Represents a debit adjustment of premium liability for the State. These actions are the result of either the accretion eff. date or the deletion eff. date of an existing master on the TPM.	X	Z
49	99	Informs the State that a request to correct the sex code, buyin eligibility code, or a welfare id # on a master rcd was rejected because the claim # or St agncy code in the code 99 didn't match a TPM	Z	X
86		Informs the alert State that an indvdl in its jurisdiction is entitled to SSI benefits and may be eligible for buyin. The individual's SSI and Medicare entitlement dates are contained in the record.	Y	Y
87		Informs the alert State that SSI entitlement has terminated for an individual who is on the buyin rolls as a code 41.	Z	Y
91		Not used by Indiana.	Z	Y

Section 11: Buy-In Premium TXN Codes

T_CDE_BUY_PREM Table

PURPOSE

Lists the valid modifier for Buy-In premium processing.

Table 11.1 – T_CDE_BUY_PREM

Modifier	Description
50	Deletion code used by the State against a code 1165 accretion posted to the State's buyin acct by a clerical action in the TPM. Code 50 may be used to annul buyin coverage or to enter a termination dt
51	Deletion code used by the State to delete an indvdl from the State's buyin acct because the indvdl is no longer a member of the State's Buy-In account. This code is not to be used for death deletes.
53	Deletion code used by the State to delete an indvdl from the State's buyin acct because the indvdl is deceased. The eff. date of the deletion must be the month and year of death.
61	Used by the State to accrete an indvdl to the State's buyin acct. It is to be used for indvdl's for whom the State has accretion responsibility.
62	Used only for an item which previously was submitted as a code 61 accretion and was rejected by the Third Party System as a code 2161 because it didn't match a HI Master record.
63	Used by the State to identify accretion records for subsequent State analysis. The code 63 is processed in exactly the same manner as the code 61.
64	Not used by Indiana.
75	Used by the State as the accretion portion of a simultaneous accretion/deletion action to establish a closed period of buyin coverage for an individual. Must be paired with a code 76 deletion record.
76	Used by the State as the deletion portion of a simultaneous accretion/deletion action to establish a closed period of buyin coverage for an indvdl. The code must be paired with a code 75 accretion rcd
81	Not used by Indiana.
84	Used by alert States to accrete an indvdl to the buyin acct following the receipt of a code 86 SSI accretion alert record. The code 84 is processed in exactly the same manner as the code 61.
99	Used by the State to correct the sex code, the buyin eligibility code, or the welfare identification number on an existing buyin record on the TPM.

Section 12: Casualty Case Status

T_CAS_CASE_STATUS Table

PURPOSE

Lists the status codes for casualty cases reviewed by the Third Party Liability (TPL) unit.

Table 12.1 – T_CAS_CASE_STATUS

Status Code	Description
A	CLOSED FULL AMOUNT - ATTORNEY FEE
C	IN COMPROMISE
F	CLOSED FULL AMOUNT
I	INTAKE
L	LEAD REV
M	CLOSED PARTIAL RECOVERY MINUS FEES
N	NO FURTHER PURSUIT
O	OPEN CASE
P	PARTIAL RECOVERY NO FEES
X	CLOSED NO RECOVERY

Section 13: Casualty Case Type

T_CAS_CASE_TYPE Table

PURPOSE

Lists the type of casualty case reviewed by the TPL unit.

Table 13.1 – T_CAS_CASE_TYPE

Type Code	Description
A	ACCIDENT/INJURY
M	MAL-PRACTICE
W	WORKERS COMPENSATION

Section 14: Casualty Letters

T_CAS_LTR_TYPE Table

PURPOSE

Lists the type of letters generated by the TPL Unit for casualty cases and the file name on the local area network (LAN) for these letters.

Table 14.1 – T_CAS_LTR_TYPE

Code	Description	File Name
A1	AMENDED-RECIPIENT/TORTFEASOR	TPLC0002.DOC
A2	AMENDED-ATTORNEY/INSURANCE	TPLC0001.DOC
C1	CLAIMS-PAID	TPLC0007.DOC
C2	CLAIMS-ZERO	TPLC0008.DOC
K1	CW-CASE NOT PURSUED	TPLC0011.DOC
K2	CW-NEED CASUALTY REPORT	TPLC0010.DOC
K3	CW-NEED ADDL INFORMATION	TPLC0009.DOC
L1	NOTICE LIEN	TPLC0020.DOC
L2	AMENDED LIEN	TPLC0003.DOC
L3	RELEASE LIEN	TPLC0027.DOC
M1	MP-RECIPIENT	TPLC0016.DOC
M2	MP-RECIPIENTS ATTY	TPLC0015.DOC
M3	MP-TORTFEASOR/PROVIDER	TPLC0018.DOC
M4	MP-TORTFEASOR/PROVIDER INSURAN	TPLC0017.DOC
M5	MP-PATIENT COMP FUND	TPLC0014.DOC
M6	MP-PLANTIFF LEAD	TPLC0013.DOC
N1	NOTICE-RECIPIENT-NO ATTY	TPLC0022.DOC
N2	NOTICE-RECIPIENT-WITH ATTY	TPLC0023.DOC
N3	NOTICE-RECIPIENTS ATTORNEY	TPLC0021.DOC
N4	NOTICE-TORTFEASOR	TPLC0026.DOC
N5	NOTICE-TORTFEASORS ATTORNEY	TPLC0024.DOC
N6	NOTICE-TORTFEASORS INSURANCE	TPLC0025.DOC
N7	NOTICE-CASE WORKER	TPLC0019.DOC
O1	ATTORNEY FEES-25%	TPLC0004.DOC
O2	ATTORNEY FEES-33 1/3%	TPLC0005.DOC

Table 14.1 – T_CAS_LTR_TYPE

Code	Description	File Name
O3	CHECK RECIEVED/CASE CLOSED	TPLC0006.DOC
R1	MEDICAL AUTHORIZATION	TPLC0012.DOC
S1	STATUS A.G. REFERAL	TPLC0030.DOC
S2	STATUS-ADDL. EXPENSES	TPLC0028.DOC
S3	STATUS	TPLC0029.DOC
W1	WORK COMP INSURANCE CO	TPLC0032.DOC
W2	WORK COMP TORTFEASOR	TPLC0036.DOC
W3	WORK COMP RECIPIENT	TPLC0034.DOC
W4	WORK COMP RECIPIENT ATTY	TPLC0033.DOC
W5	WORK COMP INDUSTRIAL BOARD	TPLC0031.DOC
W6	WORK COMP TORTFEASOR ATTY	TPLC0035.DOC

Section 15: Claim Type MMIS Batch

T_CT_MMIS_BATCH Table

PURPOSE

Lists the valid batch ranges for the corresponding claim types in Indiana*AIM*.

Table 15.1 – T_CT_MMIS_BATCH

Claim Type	Sequence	Beginning Batch Range	Ending Batch Range
D	1	370	379
D	2	660	689
F	1	700	730
H	1	640	649
H	2	989	999
I	1	500	517
I	2	518	519
I	3	56	199
I	4	950	974
L	1	520	538
L	2	539	539
L	3	540	598
L	4	56	199
M	1	300	369
M	2	380	399
M	3	800	809
M	4	830	848
M	5	849	849
O	1	600	639
O	2	975	988
P	1	400	499
P	2	850	949
X	1	0	49
X	2	50	55

Section 16: Coinsurance Deductible Premium Schedule Code

T_COIN_DE_SCH Table

PURPOSE

List the codes used by the HIPP process to indicate how frequent the coinsurance and deductibles of private pay plans are renewed.

Table 16.1 – T_COIN_DE_SCH

Code	Description
A	Annual
B	Biweekly
M	Per Month
O	Other
Q	Per Quarter
R	Per Prescription
U	Unknown
V	Per Visit
W	Per Week

Section 17: Condition Code

T_CONDITION Table

PURPOSE

Lists the valid condition codes that can be used on an UB-92 claim form.

Table 17.1 – T_CONDITION

Code	Description
02	Condition Is Employment Related
03	Patient Is Cvrd By Ins Not Reflect Here
05	Lien Has Been Filed
40	Same Day Transfer
60	Day Outlier
61	Cost Outlier
82	Non-Covered By Other Insurance
A7	Induced Abortion, Danger To Life
A8	Induced Abortion, Victim Of Rape/Incest
X0	Psychiatric (Distinct Part)
X1	Rehabilitation (Distinct Part)

Section 18: County

T_COUNTY Table

PURPOSE

Lists the counties in Indiana, plus a generic for out of state, with their addresses and designated ICES county code.

Table 18.1 – T_COUNTY

County Code	Locality	Name	Address 1	Address 2	City	ZIP	Managed Care eligible	Managed Care State Region	Urban or Rural for Managed Care	ID Card Control Number
01	3	Adams	Adams County D.F.C.	P.O. Box 227	Decatur	46733	Y	N	R	26601
02	1	Allen	Allen County D.F.C.	201 E Rudisell Blvd, Suite 100	Ft. Wayne	46806	Y	N	U	26602
03	2	Bartholomew	Bartholomew County D.F.C.	P.O. Box 587	Columbus	47202	Y	S	R	26603
04	3	Benton	Benton County D.F.C.	P.O. Box 226	Fowler	47944	Y	C	R	26604
05	3	Blackford	Blackford County D.F.C.	P.O. Box 717	Hartford City	47348	Y	C	R	26605
06	3	Boone	Boone County D.F.C.	P.O. Box 548	Lebanon	46052	Y	C	U	26606
07	3	Brown	Brown County	P.O. Box 325	Nashville	47448	Y	S	R	26607

Table 18.1 – T_COUNTY

County Code	Locality	Name	Address 1	Address 2	City	ZIP	Managed Care eligible	Managed Care State Region	Urban or Rural for Managed Care	ID Card Control Number
			D.F.C.							
08	2	Carroll	Carroll County D.F.C.	P.O. Box 276	Delphi	46923	Y	C	R	26608
09	2	Cass	Cass County D.F.C.	1714 Dividend Drive	Logansport	46947	Y	N	R	26609
10	2	Clark	Clark County D.F.C.	1200 Madison Street	Clarksville	47129	Y	S	U	26610
11	3	Clay	Clay County D.F.C.	P.O. Box 433	Brazil	47834	Y	S	U	26611
12	3	Clinton	Clinton County D.F.C.	P.O. Box 725	Frankfort	46041	Y	C	R	26612
13	3	Crawford	Crawford County D.F.C.	P.O. Box 129	English	47118	Y	S	R	26613
14	2	Daviess	Daviess County D.F.C.	P.O. Box 618	Washington	47501	Y	S	R	26614
15	3	Dearborn	Dearborn County D.F.C.	230 Mary Avenue, Suite 150	Lawrenceburg	47025	Y	S	U	26615
16	3	Decatur	Decatur County D.F.C.	1025 E. Freeland Rd., Suite B	Greensburg	47240	Y	S	R	26616
17	3	Dekalb	Dekalb County	P.O. Box 870	Auburn	46706	Y	N	U	26617

Table 18.1 – T_COUNTY

County Code	Locality	Name	Address 1	Address 2	City	ZIP	Managed Care eligible	Managed Care State Region	Urban or Rural for Managed Care	ID Card Control Number
			D.F.C.							
18	1	Delaware	Delaware County D.F.C.	P.O. Box 1528	Muncie	47308	Y	C	U	26618
19	3	Dubois	Dubois County D.F.C.	P.O. Box 230	Jasper	47547	Y	S	R	26619
20	2	Elkhart	Elkhart County D.F.C.	347 West Lusher Avenue	Elkhart	46517	Y	N	U	26620
21	3	Fayette	Fayette County D.F.C.	1720 Western Avenue	Connersville	47331	Y	C	R	26621
22	2	Floyd	Floyd County D.F.C.	1421 East Elm Street	New Albany	47150	Y	S	U	26622
23	3	Fountain	Fountain County Dfc	981 East State Street, Suite A	Veedersburg	47987	Y	C	R	26623
24	3	Franklin	Franklin County D.F.C.	9127 Oxford Pike, Suite A	Brookville	47012	Y	S	R	26624
25	3	Fulton	Fulton County D.F.C.	1920 Rhodes Street	Rochester	46975	Y	N	R	26625
26	3	Gibson	Gibson County D.F.C.	321 South 5th St.	Princeton	47670	Y	S	R	26626
27	2	Grant	Grant County D.F.C.	840 N. Miller Avenue	Marion	46952	Y	C	R	26627
28	3	Greene	Greene County D.F.C.	P.O. Box 443	Bloomfield	47424	Y	S	R	26628

Table 18.1 – T_COUNTY

County Code	Locality	Name	Address 1	Address 2	City	ZIP	Managed Care eligible	Managed Care State Region	Urban or Rural for Managed Care	ID Card Control Number
29	3	Hamilton	Hamilton County D.F.C.	938 N. 10th Street	Noblesville	46060	Y	C	U	26629
30	2	Hancock	Hancock County D.F.C.	120 W. Mckenzie, Suite F	Greenfield	46140	Y	C	U	26630
31	3	Harrison	Harrison County D.F.C.	P.O. Box 366	Corydon	47112	Y	S	R	26631
32	2	Hendricks	Hendricks County D.F.C.	6781 East Us 36 Suite 200	Avon	46123	Y	C	U	26632
33	2	Henry	Henry County D.F.C.	1416 Broad Street, 2nd Floor	New Castle	47362	Y	C	R	26633
34	2	Howard	Howard County D.F.C.	101 West Superior, Suite A	Kokomo	46901	Y	C	U	26634
35	3	Huntington	Huntington County D.F.C.	88 Home Street	Huntington	46750	Y	N	R	26635
36	3	Jackson	Jackson County D.F.C.	P.O. Box C	Brownstown	47220	Y	S	R	26636
37	3	Jasper	Jasper County D.F.C.	P.O. Box 279	Rensselaer	47978	Y	N	R	26637
38	3	Jay	Jay County D.F.C.	P.O. Box 1034	Portland	47371	Y	C	R	26638
39	3	Jefferson	Jefferson County	P.O. Box	Madison	47250	Y	S	R	26639

Table 18.1 – T_COUNTY

County Code	Locality	Name	Address 1	Address 2	City	ZIP	Managed Care eligible	Managed Care State Region	Urban or Rural for Managed Care	ID Card Control Number
			D.F.C.	1189						
40	3	Jennings	Jennings County D.F.C.	P.O. Box 1047	North Vernon	47265	Y	S	R	26640
41	2	Johnson	Johnson County D.F.C.	P.O. Box 489	Franklin	46131	Y	C	U	26641
42	2	Knox	Knox County D.F.C.	P.O. Box 235	Vincennes	47591	Y	S	R	26642
43	2	Kosciusko	Kosciusko County D.F.C.	205 North Lake St.	Warsaw	46580	Y	N	R	26643
44	2	Lagrange	Lagrange County D.F.C.	421-B S. Detroit St.	LaGrange	46761	Y	N	R	26644
45	1	Lake	Lake County D.F.C.	839 Broadway	Gary	46402	Y	N	U	26645
46	1	Laporte	Laporte County D.F.C.	P.O. Box 1402	LaPorte	46350	Y	N	R	26646
47	2	Lawrence	Lawrence County D.F.C.	918 16th Street, Suite 100	Bedford	47421	Y	S	R	26647
48	1	Madison	Madison County D.F.C.	222 East 10th Street Suite D	Anderson	46016	Y	C	U	26648
49	1	Marion	Marion County D.F.C.	129 E Market St., Suite 1200	Indianapolis	46204	Y	C	U	26649
50	3	Marshall	Marshall County D.F.C.	P.O. Box 539	Plymouth	46593	Y	N	R	26650

Table 18.1 – T_COUNTY

County Code	Locality	Name	Address 1	Address 2	City	ZIP	Managed Care eligible	Managed Care State Region	Urban or Rural for Managed Care	ID Card Control Number
51	3	Martin	Martin County D.F.C.	51 Ravine Street, P.O.Box 88	Shoals	47581	Y	S	R	26651
52	3	Miami	Miami County D.F.C.	P.O. Box 143	Peru	46970	Y	N	R	26652
53	2	Monroe	Monroe County D.F.C.	401 East Miller Dr.	Bloomington	47401	Y	S	U	26653
54	3	Montgomery	Montgomery County D.F.C.	307 Binford Street	Crawfordsville	47933	Y	C	R	26654
55	3	Morgan	Morgan County D.F.C.	1326 South Morton Avenue	Martinsville	46151	Y	C	U	26655
56	3	Newton	Newton County D.F.C.	P.O. Box 520	Morocco	47963	Y	N	R	26656
57	3	Noble	Noble County D.F.C.	107 Weber Road	Albion	46701	Y	N	R	26657
58	3	Ohio	Ohio County D.F.C.	P.O. Box 196	Rising Sun	47040	Y	S	R	26658
59	3	Orange	Orange County D.F.C.	P.O. Box 389	Paoli	47454	Y	S	R	26659
60	3	Owen	Owen County D.F.C.	14 N. Washington St	Spencer	47460	Y	S	R	26660
61	3	Parke	Parke County D.F.C.	116 West Ohio	Rockville	47872	Y	C	R	26661

Table 18.1 – T_COUNTY

County Code	Locality	Name	Address 1	Address 2	City	ZIP	Managed Care eligible	Managed Care State Region	Urban or Rural for Managed Care	ID Card Control Number
62	3	Perry	Perry County D.F.C.	316 E. Hwy. 66	Tell City	47586	Y	S	R	26662
63	3	Pike	Pike County D.F.C.	2105 East Main	Petersburg	47567	Y	S	R	26663
64	1	Porter	Porter County D.F.C.	152 Indiana Avenue	Valparaiso	46383	Y	N	U	26664
65	3	Posey	Posey County D.F.C.	P.O. Box 568	Mount Vernon	47620	Y	S	U	26665
66	3	Pulaski	Pulaski County D.F.C.	P.O. Box 130	Winamac	46996	Y	N	R	26666
67	3	Putnam	Putnam County D.F.C.	620 Tennessee St., Suite 1	Greencastle	46135	Y	C	R	26667
68	3	Randolph	Randolph County D.F.C.	2 Omco Square, Suite 200	Winchester	47394	Y	C	R	26668
69	3	Ripley	Ripley County D.F.C.	P.O. Box 215	Versailles	47042	Y	S	R	26669
70	3	Rush	Rush County D.F.C.	1340 North Cherry	Rushville	46173	Y	C	R	26670
71	2	St. Joseph	St. Joseph County D.F.C.	P.O. Box 4638	South Bend	46634	Y	N	U	26671
72	3	Scott	Scott County D.F.C.	P.O. Box 424	Scottsburg	47170	Y	S	R	26672

Table 18.1 – T_COUNTY

County Code	Locality	Name	Address 1	Address 2	City	ZIP	Managed Care eligible	Managed Care State Region	Urban or Rural for Managed Care	ID Card Control Number
73	1	Shelby	Shelby County D.F.C.	P.O. Box 849	Shelbyville	46176	Y	C	U	26673
74	3	Spencer	Spencer County D.F.C.	P.O. Box 25	Rockport	47635	Y	S	R	26674
75	3	Starke	Starke County D.F.C.	318 E. Culver Rd.	Knox	46534	Y	N	R	26675
76	3	Steuben	Steuben County D.F.C.	317s Wayne St Ste 2a	Angola	46703	Y	N	R	26676
77	3	Sullivan	Sullivan County D.F.C.	P.O. Box 348	Sullivan	47882	Y	S	R	26677
78	3	Switzerland	Switzerland County D.F.C.	P.O. Box 98	Vevay	47043	Y	S	R	26678
79	2	Tippecanoe	Tippecanoe County D.F.C.	111 North 4th Street	Lafayette	47901	Y	C	U	26679
80	3	Tipton	Tipton County D.F.C.	Courthouse-Box 36	Tipton	46072	Y	C	U	26680
81	3	Union	Union County D.F.C.	P.O. Box 344	Liberty	47353	Y	C	R	26681
82	1	Vanderburgh	Vanderburgh County D.F.C.	P.O. Box 154	Evansville	47701	Y	S	U	26682
83	3	Vermillion	Vermillion County D.F.C.	P.O. Box 218	Newport	47966	Y	C	R	26683
84	2	Vigo	Vigo County D.F.C.	30 North 8th ST	Terre Haute	47807	Y	S	U	26684

Table 18.1 – T_COUNTY

County Code	Locality	Name	Address 1	Address 2	City	ZIP	Managed Care eligible	Managed Care State Region	Urban or Rural for Managed Care	ID Card Control Number
85	3	Wabash	Wabash County D.F.C.	89 West Canal Street	Wabash	46992	Y	N	R	26685
86	3	Warren	Warren County D.F.C.	20 West Second Street	Williamsport	47993	Y	C	R	26686
87	3	Warrick	Warrick County D.F.C.	P.O. Box 265	Boonville	47601	Y	S	U	26687
88	3	Washington	Washington County D.F.C.	13 E Westminster Center St 104	Salem	47167	Y	S	R	26688
89	2	Wayne	Wayne County D.F.C.	25 South Second	Richmond	47374	Y	C	R	26689
90	2	Wells	Wells County D.F.C.	P.O. Box 495	Bluffton	46714	Y	N	R	26690
91	3	White	White County D.F.C.	715 N. Main St	Monticello	47960	Y	N	R	26691
92	3	Whitley	Whitley County D.F.C.	115 S. Line Street	Columbia City	46725	Y	N	U	26692
94	3	IFSSA					N	N	R	
98	7	Oos-Ward Crt					N	N	R	
99	7	Out Of State					N	N	R	

Section 19: County Quadrant

T_COUNTY_QUAD Table

PURPOSE

For Managed Care, Marion County is broken into four quadrants by ZIP code to limit auto-assignments to a close geographic area. This table list the quadrant codes for each ZIP code.

Table 19.1 – T_COUNTY_QUAD

County	ZIP	Quadrant Code
49	46107	1
49	46201	1
49	46203	1
49	46219	1
49	46227	1
49	46229	1
49	46237	1
49	46239	1
49	46259	1
49	46205	2
49	46216	2
49	46218	2
49	46220	2
49	46226	2
49	46236	2
49	46240	2
49	46250	2
49	46256	2
49	46280	2
49	46202	3
49	46208	3
49	46214	3
49	46222	3
49	46224	3

Table 19.1 – T_COUNTY_QUAD

County	ZIP	Quadrant Code
49	46234	3
49	46254	3
49	46260	3
49	46268	3
49	46278	3
49	46290	3
49	46113	4
49	46183	4
49	46204	4
49	46217	4
49	46221	4
49	46225	4
49	46231	4
49	46241	4

Section 20: Court Ordered Code

T_COURT_ORD_CDE Table

PURPOSE

Lists the type of TPL coverage, if any, ordered by the court.

Table 20.1 – T_COURT_ORD_CDE

Code	Description
B	Birth Expenses
C	Child Support
I	Medical Insurance
M	Medical Support
N	No Child Support Or Medical Support
P	Partial Medical Support
Z	Any Combination Of The Above

Section 21: Coverage – Diagnosis Xref

T_COV_DIAG_XREF Table

PURPOSE

Lists the diagnosis codes or claim types covered by certain TPL coverage codes. This is to determine if a claim should be cost avoided or rebilled.

Talbe 21.1 – T_COV_DIAG_XREF

Coverage Code	Claim Type	Diagnosis From	Diagnosis To
F	I	140	20899
F	M	140	20899
F	O	140	20899
K	I	290	31999
K	O	290	31999

Section 22: Coverage – Procedure Code Xref

T_COV_PROC_XREF Table

PURPOSE

Lists the procedure codes covered by certain TPL coverage codes.
This is used to determine if a claim should be cost avoided or rebilled.

Table 22.1 – T_COV_PROC_XREF

Coverage Code	Claim Type	Procedure From	Procedure To
N	M	99201	99499
N	M	70010	79999
N	M	80002	89399
N	M	A0010	E1700
N	M	L0100	L8690
N	O	99201	99499
N	O	70010	79999
N	O	80002	89399
N	O	A0010	E1700
N	O	L0100	L8690
I	M	92002	92499
I	M	V2020	V2799
I	M	Y5100	Y5107
I	M	Y7603	Y7603
I	M	Z0105	Z3033
I	M	Z4785	Z4807
I	M	Z5000	Z5011
I	M	Z7777	Z7777

Section 23: Coverage – Provider Specialty Xref

T_COV_SPEC_XREF Table

PURPOSE

Lists the provider specialties covered by certain TPL coverage codes. This is used to determine if a claim should be cost avoided or rebilled.

Table 23.1 – T_COV_SPEC_XREF

Coverage Code	Provider Specialty	Claim Type
C	262	I
C	262	M
C	262	O
C	263	I
C	263	M
C	263	O
C	264	I
C	264	M
C	264	O
C	265	I
C	265	M
C	265	O
C	266	I
C	266	M
C	266	O
I	330	M
K	339	M
N	114	M
N	114	O
N	115	M
N	115	O
N	116	M
N	116	O
N	339	M
N	339	O

Section 24: Coverage – Provider Type Xref

T_COV_TYPE_XREF Table

PURPOSE

Lists the provider types covered by certain TPL coverage codes. This is used to determine if a claim should be cost avoided or rebilled.

Table 24.1 – T_COV_TYPE_XREF

Coverage Code	Provider Type	Claim Type
B	07	M
B	14	M
B	18	M
B	19	M
B	25	M
B	26	M
C	07	I
C	07	M
C	07	O
C	18	I
C	18	M
C	18	O
C	19	I
C	19	M
C	19	O
I	18	M
I	19	M
K	11	M
Q	07	M
Q	14	M
Q	18	M
Q	19	M
Q	25	M
Q	26	M

Section 25: Coverage – Revenue Code Xref

T_COV_REV_XREF Table

PURPOSE

Lists the revenue codes covered by certain TPL coverage codes. This is used to determine if a claim should be cost avoided or rebilled.

Table 25.1 – T_COV_REV_XREF

Coverage Type	Claim Type	Revenue From	Revenue To
K	I	900	919
K	O	900	919
N	O	250	252
N	O	254	255
N	O	258	260
N	O	270	272
N	O	274	280
N	O	289	289
N	O	300	307
N	O	309	312
N	O	314	314
N	O	319	324
N	O	329	331
N	O	333	333
N	O	335	335
N	O	339	342
N	O	349	352
N	O	359	361
N	O	369	372
N	O	379	391
N	O	399	403
N	O	409	410
N	O	412	413
N	O	419	422
N	O	424	424

Table 25.1 – T_COV_REV_XREF

Coverage Type	Claim Type	Revenue From	Revenue To
N	O	429	432
N	O	434	434
N	O	439	442
N	O	444	444
N	O	449	450
N	O	459	460
N	O	469	472
N	O	479	482
N	O	489	490
N	O	499	499
N	O	510	510
N	O	519	519
N	O	530	531
N	O	539	545
N	O	549	549
N	O	610	612
N	O	619	619
N	O	621	622
N	O	634	636
N	O	700	700
N	O	709	710
N	O	719	721
N	O	724	724
N	O	729	729
N	O	730	732
N	O	740	740
N	O	749	750
N	O	760	760
N	O	769	769
N	O	790	790
N	O	820	821
N	O	830	831
N	O	840	841

Table 25.1 – T_COV_REV_XREF

Coverage Type	Claim Type	Revenue From	Revenue To
N	O	850	851
N	O	900	901
N	O	909	912
N	O	914	917
N	O	920	924
N	O	929	929
N	O	940	940
N	O	942	945
N	O	947	947
N	O	949	949

Section 26: Coverage Type

T_COVERAGE_TYPE Table

PURPOSE

Lists the valid TPL coverage types.

Table 26.1 – T_COVERAGE_TYPE

Code	Description
A	Hospitalization
B	Medical
C	Major Medical
D	Dental
E	Pharmacy
F	Cancer
G	Skilled Care In A Nursing Facility
H	Home Health
I	Optical/Vision
K	Mental Health
L	Indemnity
O	Medicare Supplemental Insurance For Part A (Also Enter 'E' If Pharmacy And/Or 'G' Or 'Z' If Nursing Facility Coverage)
P	Medicare Supplemental Insurance For Part B (Also Enter 'E' If Pharmacy And/Or 'G' Or 'Z' If Nursing Facility Coverage)
Q	Hospitalization, Medical And Major Medical
Z	Intermediate Care In A Nursing Facility

Section 27: Coverage Type of Bill Xref

T_COV_BILL_XREF Table

PURPOSE

Lists the types of bill covered by certain TPL coverage codes. This is used to determine if a claim should be cost avoided or rebilled.

Table 27.1 – T_COV_BILL_XREF

Coverage Code	Claim Type	Type of Bill From	Type of Bill To
G	L	200	299
O	C	330	339
P	C	000	999
Z	L	600	699

Section 28: DEA Code

T_DEA_CODE Table

PURPOSE

Lists the valid DEA codes for drugs listed in Indiana*AIM*.

Table 28.1 – T_DEA_CODE

Code	Description
5	Controlled sale by pharmacy only
4	Valium, etc. - Potential abuse
3	Aspirin/Codeine, etc. - Less abused
2	Morphine, Meperidine, Amphetamines, etc. - Most abused
1	LSD, Heroin, Marijuana - Research only
0	No control

Section 29: DESI Code

T_DESI_CODE Table

PURPOSE

Lists the valid DESI codes for drugs in Indiana*AIM*.

Table 29.1 – T_DESI_CODE

Code	Description
2	Safe and Effective or Non-Desi
3	Desi/IRS Drugs Under Review (No NOOH Issued)
4	Less than Effective Desi/IRS Drugs for Some Indications
5	Less than Effective Desi/IRS Drugs for All Indications
6	Less than Effective Desi/IRS Drugs Removed From the Market

Section 30: Diagnosis Type

T_DIAG_TYPE Table

PURPOSE

List the types of diagnosis codes used by the Reference subsystem. This grouping is the same type of diagnosis codes that are used in editing to streamline the process. Some edits are set against types of diagnosis as opposed to listing all the diagnosis codes in the edit.

Table 30.1 – T_DIAG_TYPE

Type	Description
1	High Risk Pregnancy Combo
2	High Risk Pregnancy
3	New Born
4	Unspecified Administrativ
5	Prenatal Care
6	Pregnancy
7	Preventative Pediatric
8	Cancer
9	Mental Health
10	Abortion
11	Sterilization
12	EPSDT1
13	EPSDT2
14	EPSDT3
15	EPSDT4
16	EPSDT5
17	High Risk Pregnancy 2
18	Vascular Diagnostic Study
19	HBO Therapy
20	EPSDT6
21	Emergency
22	Family Plan 1 (Edit 1011)
23	Family Plan 2 (Edit 1011)

Table 30.1 – T_DIAG_TYPE

Type	Description
24	Excluded (Edit 1011)
25	PAS Exception
26	RBMC Exclude Diag (2017)
27	EPSDT7 HCFA-416
28	EPSDT8 HCFA-416
29	EPSDT9 HCFA-416
30	EPSDT10 HCFA-416
31	SOBRA Pregnant women
32	Accident/Trauma
33	Out of State - Antepartum/Delivery
35	trauma codes
36	TPL Birth Expenditures
37	Sterilization MAR/MSIS
38	Abortions MAR/MSIS
39	Family Planning MAR/MSIS

Section 31: Disenrollment Reasons

T_MC_DISENR_RSN Table

PURPOSE

Lists the reasons a member would be automatically disenrolled from a PMP in Hoosier Healthwise.

Table 31.1 – T_MC_DISENR_RSN

Code	Description
PA	Voluntary Disenroll
PB	Provider Medicaid Eligibility Terminated
PC	Group Medicaid Eligibility Terminated
PD	PMP Specialty Changed to NonManaged Care
PE	PMP Service Location No Longer Active
PF	PMP Group Enrollment Terminated
PG	Mandatory Disenrollment
PM	MCO Dsnrl - PMP Reenrolls with new MCO
PP	MCO Dsnrl - PMP Reenrolls in PCCM
PS	MCO Dsnrl - PMP does not enrolls in Pgm

Section 32: Dispensing Fee

T_DISP_FEE Table

PURPOSE

Lists the maximum allowed dispensing fee by provider specialty.

Table 32.1 – T_DISP_FEE

Provider Specialty	Effective Date	End Date	Dispensing Fee
240	19900101	22991231	4
250	19900101	22991231	4

Section 33: DRG Mapper

T_DRG_MAPPER Table

PURPOSE

Lists the diagnosis and procedure codes that are not recognized by the versions of the DRG grouper used by Indiana*AIM*. An equivalent code that is recognized by the grouper versions is also located on the table to be used by the grouper.

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	00581	19951001	19970930	0058
B	1	00589	19951001	19970930	0058
B	1	0074	19971001	22991231	0078
B	1	0080	19871001	19920930	00800
B	1	0086	19871001	19920930	00869
B	1	0312	19971001	22991231	0318
B	1	03810	19971001	22991231	0381
B	1	03811	19971001	22991231	0381
B	1	03819	19971001	22991231	0381
B	1	0410	19871001	19920930	04100
B	1	0411	19871001	19920930	04110
B	1	0418	19871001	19920930	04189
B	1	04186	19951001	19970930	04184
B	1	042	19941001	19970930	0420
B	1	0702	19871001	19910930	07020
B	1	07022	19941001	19970930	07020
B	1	07023	19941001	19970930	07021
B	1	0703	19871001	19910930	07030
B	1	07032	19941001	19970930	07030
B	1	07033	19941001	19970930	07031
B	1	0704	19871001	19910930	07041
B	1	07044	19941001	19970930	07041

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	0705	19871001	19910930	07051
B	1	07054	19941001	19970930	07051
B	1	0779	19871001	19930930	07799
B	1	0781	19871001	19930930	07810
B	1	0796	19961001	19970930	07989
B	1	0798	19871001	19930930	07989
B	1	07981	19951001	19970930	07989
B	1	0799	19871001	19930930	07999
B	1	0888	19871001	19890930	08889
B	1	0994	19871001	19920930	09949
B	1	2030	19871001	19910930	20300
B	1	2031	19871001	19910930	20310
B	1	2038	19871001	19910930	20380
B	1	2040	19871001	19910930	20400
B	1	2041	19871001	19910930	20410
B	1	2042	19871001	19910930	20420
B	1	2048	19871001	19910930	20480
B	1	2049	19871001	19910930	20490
B	1	2050	19871001	19910930	20500
B	1	2051	19871001	19910930	20510
B	1	2052	19871001	19910930	20520
B	1	2053	19871001	19910930	20530
B	1	2058	19871001	19910930	20580
B	1	2059	19871001	19910930	20590
B	1	2060	19871001	19910930	20600
B	1	2061	19871001	19910930	20610
B	1	2062	19871001	19910930	20620
B	1	2068	19871001	19910930	20680
B	1	2069	19871001	19910930	20690
B	1	2070	19871001	19910930	20700
B	1	2071	19871001	19910930	20710
B	1	2072	19871001	19910930	20720

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	2078	19871001	19910930	20780
B	1	2080	19871001	19910930	20800
B	1	2081	19871001	19910930	20810
B	1	2082	19871001	19910930	20820
B	1	2088	19871001	19910930	20880
B	1	2089	19871001	19910930	20890
B	1	2377	19871001	19900930	23770
B	1	27540	19971001	22991231	2754
B	1	27541	19971001	22991231	2754
B	1	27542	19971001	22991231	2754
B	1	27549	19971001	22991231	2754
B	1	27800	19951001	19970930	2780
B	1	27801	19951001	19970930	2780
B	1	2831	19871001	19930930	28310
B	1	29181	19961001	19970930	2918
B	1	29189	19961001	19970930	2918
B	1	29384	19961001	19970930	29389
B	1	30082	19961001	19970930	30081
B	1	3051	19941001	19970930	30510
B	1	31281	19941001	19970930	3128
B	1	31282	19941001	19970930	3128
B	1	31289	19941001	19970930	3128
B	1	31532	19961001	19970930	31539
B	1	3208	19871001	19920930	32089
B	1	33392	19941001	19970930	33399
B	1	33393	19941001	19970930	33399
B	1	3373	19981001	19990514	33729
B	1	34200	19941001	19970930	3420
B	1	34201	19941001	19970930	3420
B	1	34202	19941001	19970930	3420
B	1	34210	19941001	19970930	3421
B	1	34211	19941001	19970930	3421

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	34212	19941001	19970930	3421
B	1	34280	19941001	19970930	3429
B	1	34281	19941001	19970930	3429
B	1	34282	19941001	19970930	3429
B	1	34290	19941001	19970930	3429
B	1	34291	19941001	19970930	3429
B	1	34292	19941001	19970930	3429
B	1	34400	19941001	19970930	3440
B	1	34401	19941001	19970930	3440
B	1	34402	19941001	19970930	3440
B	1	34403	19941001	19970930	3440
B	1	34404	19941001	19970930	3440
B	1	34409	19941001	19970930	3440
B	1	34430	19941001	19970930	3443
B	1	34431	19941001	19970930	3443
B	1	34432	19941001	19970930	3443
B	1	34440	19941001	19970930	3444
B	1	34441	19941001	19970930	3444
B	1	34442	19941001	19970930	3444
B	1	3448	19871001	19930930	34489
B	1	3450	19871001	19890930	34500
B	1	3451	19871001	19890930	34510
B	1	3454	19871001	19890930	34540
B	1	3455	19871001	19890930	34550
B	1	3456	19871001	19890930	34560
B	1	3457	19871001	19890930	34570
B	1	3458	19871001	19890930	34580
B	1	3459	19871001	19890930	34590
B	1	3460	19871001	19920930	34600
B	1	3461	19871001	19920930	34610
B	1	3462	19871001	19920930	34620
B	1	3468	19871001	19920930	34680

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	3469	19871001	19920930	34690
B	1	3557	19871001	19930930	35579
B	1	4030	19871001	19890930	40300
B	1	4031	19871001	19890930	40310
B	1	4039	19871001	19890930	40390
B	1	4040	19871001	19890930	40400
B	1	4041	19871001	19890930	40410
B	1	4049	19871001	19890930	40490
B	1	4100	19871001	19890930	41001
B	1	4101	19871001	19890930	41011
B	1	4102	19871001	19890930	41021
B	1	4103	19871001	19890930	41031
B	1	4104	19871001	19890930	41041
B	1	4105	19871001	19890930	41051
B	1	4106	19871001	19890930	41061
B	1	4107	19871001	19890930	41071
B	1	4108	19871001	19890930	41081
B	1	4109	19871001	19890930	41091
B	1	4118	19871001	19890930	41189
B	1	41400	19941001	19970930	4140
B	1	41401	19941001	19970930	4140
B	1	41402	19941001	19970930	4140
B	1	41403	19941001	19970930	4140
B	1	41404	19961001	19970930	4140
B	1	41405	19961001	19970930	4140
B	1	41511	19951001	19970930	4151
B	1	41519	19951001	19970930	4151
B	1	4330	19871001	19930930	43300
B	1	4331	19871001	19930930	43310
B	1	4332	19871001	19930930	43320
B	1	4333	19871001	19930930	43330
B	1	4338	19871001	19930930	43380

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	4339	19871001	19930930	43390
B	1	4340	19871001	19930930	43401
B	1	4341	19871001	19930930	43411
B	1	4349	19871001	19930930	43491
B	1	4353	19951001	19970930	4351
B	1	4380	19971001	22991231	438
B	1	43810	19971001	22991231	438
B	1	43811	19971001	22991231	438
B	1	43812	19971001	22991231	438
B	1	43819	19971001	22991231	438
B	1	43820	19971001	22991231	438
B	1	43821	19971001	22991231	438
B	1	43822	19971001	22991231	438
B	1	43830	19971001	22991231	438
B	1	43831	19971001	22991231	438
B	1	43832	19971001	22991231	438
B	1	43840	19971001	22991231	438
B	1	43841	19971001	22991231	438
B	1	43842	19971001	22991231	438
B	1	43850	19971001	22991231	438
B	1	43851	19971001	22991231	438
B	1	43852	19971001	22991231	438
B	1	43853	19981001	19990514	43852
B	1	43881	19971001	22991231	438
B	1	43882	19971001	22991231	438
B	1	43889	19971001	22991231	438
B	1	4389	19971001	22991231	438
B	1	4402	19871001	19920930	44020
B	1	44030	19941001	19970930	4408
B	1	44031	19941001	19970930	4408
B	1	44032	19941001	19970930	4408
B	1	44100	19941001	19970930	4410

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	44101	19941001	19970930	4410
B	1	44102	19941001	19970930	4410
B	1	44103	19941001	19970930	4410
B	1	4462	19871001	19900930	44620
B	1	4582	19951001	19970930	4589
B	1	4588	19971001	22991231	4589
B	1	46611	19961001	19970930	4661
B	1	46619	19961001	19970930	4661
B	1	47400	19971001	22991231	4740
B	1	47401	19971001	22991231	4740
B	1	47402	19971001	22991231	4740
B	1	4823	19871001	19920930	48230
B	1	48240	19981001	19990514	4824
B	1	48241	19981001	19990514	4824
B	1	48249	19981001	19990514	4824
B	1	4828	19871001	19920930	48289
B	1	48284	19971001	22991231	48283
B	1	483	19871001	19920930	4838
B	1	4831	19961001	19970930	07888
B	1	4912	19871001	19910930	49120
B	1	5121	19941001	19970930	5128
B	1	5186	19971001	22991231	51889
B	1	51883	19981001	19990514	51881
B	1	51884	19981001	19990514	51881
B	1	51900	19981001	19990514	5190
B	1	51901	19981001	19990514	5190
B	1	51902	19981001	19990514	5190
B	1	51909	19981001	19990514	5190
B	1	5240	19871001	19920930	52400
B	1	5241	19871001	19920930	52410
B	1	5246	19871001	19910930	52460
B	1	5301	19871001	19930930	53010

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	5308	19871001	19930930	53089
B	1	5350	19871001	19910930	53500
B	1	5351	19871001	19910930	53510
B	1	5352	19871001	19910930	53520
B	1	5353	19871001	19910930	53530
B	1	5354	19871001	19910930	53540
B	1	5355	19871001	19910930	53550
B	1	5356	19871001	19910930	53560
B	1	5363	19941001	19970930	5368
B	1	53640	19981001	19990514	9974
B	1	53641	19981001	19990514	9974
B	1	53642	19981001	19990514	9974
B	1	53649	19981001	19990514	9974
B	1	5560	19941001	19970930	556
B	1	5561	19941001	19970930	556
B	1	5562	19941001	19970930	556
B	1	5563	19941001	19970930	556
B	1	5564	19941001	19970930	556
B	1	5565	19941001	19970930	556
B	1	5566	19941001	19970930	556
B	1	5568	19941001	19970930	556
B	1	5569	19941001	19970930	556
B	1	56481	19981001	19990514	5648
B	1	56489	19981001	19990514	5648
B	1	56960	19971001	22991231	5696
B	1	56961	19971001	22991231	5696
B	1	56962	19981001	19990514	56969
B	1	56969	19951001	19970930	5696
B	1	57460	19961001	19970930	57400
B	1	57461	19961001	19970930	57401
B	1	57470	19961001	19970930	57410
B	1	57471	19961001	19970930	57411

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	57480	19961001	19970930	57400
B	1	57481	19961001	19970930	57401
B	1	57490	19961001	19970930	57420
B	1	57491	19961001	19970930	57421
B	1	57510	19961001	19970930	5751
B	1	57511	19961001	19970930	5751
B	1	57512	19961001	19970930	5750
B	1	59370	19941001	19970930	5937
B	1	59371	19941001	19970930	5937
B	1	59372	19941001	19970930	5937
B	1	59373	19941001	19970930	5937
B	1	5965	19871001	19920930	59659
B	1	5998	19871001	19920930	59989
B	1	65570	19971001	22991231	65580
B	1	65571	19971001	22991231	65581
B	1	65573	19971001	22991231	65583
B	1	65970	19981001	19990514	65630
B	1	65971	19981001	19990514	65631
B	1	65973	19981001	19990514	65633
B	1	66512	19871001	19930930	66511
B	1	66514	19871001	19930930	66554
B	1	66943	19941001	19970930	66983
B	1	677	19941001	19970930	67490
B	1	68600	19971001	22991231	6860
B	1	68601	19971001	22991231	6860
B	1	68609	19971001	22991231	6860
B	1	69010	19951001	19970930	690
B	1	69011	19951001	19970930	7048
B	1	69012	19951001	19970930	6918
B	1	69018	19951001	19970930	690
B	1	6908	19951001	19970930	690
B	1	702	19871001	19910930	7028

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	70211	19941001	19970930	7021
B	1	70219	19941001	19970930	7021
B	1	70900	19941001	19970930	7090
B	1	70901	19941001	19970930	7090
B	1	70909	19941001	19970930	7090
B	1	72886	19951001	19970930	7294
B	1	7331	19871001	19930930	73310
B	1	7381	19871001	19920930	73819
B	1	7476	19871001	19930930	74760
B	1	75251	19961001	19970930	7525
B	1	75252	19961001	19970930	7525
B	1	75261	19961001	19970930	7526
B	1	75262	19961001	19970930	7526
B	1	75263	19961001	19970930	7526
B	1	75264	19961001	19970930	7528
B	1	75265	19961001	19970930	7528
B	1	75269	19961001	19970930	7528
B	1	7531	19871001	19900930	75310
B	1	75320	19961001	19970930	7532
B	1	75321	19961001	19970930	7532
B	1	75322	19961001	19970930	7532
B	1	75323	19961001	19970930	7532
B	1	75329	19961001	19970930	7532
B	1	75670	19971001	22991231	7567
B	1	75671	19971001	22991231	7567
B	1	75679	19971001	22991231	7567
B	1	75881	19961001	19970930	7588
B	1	75889	19961001	19970930	7588
B	1	7598	19871001	19890930	75989
B	1	75983	19941001	19970930	75989
B	1	76076	19941001	19970930	76079
B	1	76381	19981001	19990514	7638

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	76382	19981001	19990514	7638
B	1	76383	19981001	19990514	7638
B	1	76389	19981001	19990514	7638
B	1	7640	19871001	19880930	76400
B	1	7641	19871001	19880930	76410
B	1	7642	19871001	19880930	76420
B	1	7649	19871001	19880930	76490
B	1	7650	19871001	19880930	76501
B	1	7651	19871001	19880930	76510
B	1	7800	19871001	19920930	78001
B	1	78031	19971001	22991231	7803
B	1	78039	19971001	22991231	7803
B	1	78071	19981001	19990514	7807
B	1	78079	19981001	19990514	7807
B	1	7818	19941001	19970930	7819
B	1	78603	19981001	19990514	78609
B	1	78604	19981001	19990514	78609
B	1	78605	19981001	19990514	78609
B	1	78606	19981001	19990514	78609
B	1	78607	19981001	19990514	78609
B	1	78701	19941001	19970930	7870
B	1	78702	19941001	19970930	7870
B	1	78703	19941001	19970930	7870
B	1	78791	19951001	19970930	5589
B	1	78799	19951001	19970930	7879
B	1	7882	19871001	19930930	78820
B	1	7883	19871001	19920930	78830
B	1	7884	19871001	19930930	78841
B	1	7886	19871001	19930930	78869
B	1	78900	19941001	19970930	7890
B	1	78901	19941001	19970930	7890
B	1	78902	19941001	19970930	7890

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	78903	19941001	19970930	7890
B	1	78904	19941001	19970930	7890
B	1	78905	19941001	19970930	7890
B	1	78906	19941001	19970930	7890
B	1	78907	19941001	19970930	7890
B	1	78909	19941001	19970930	7890
B	1	78930	19941001	19970930	7893
B	1	78931	19941001	19970930	7893
B	1	78932	19941001	19970930	7893
B	1	78933	19941001	19970930	7893
B	1	78934	19941001	19970930	7893
B	1	78935	19941001	19970930	7893
B	1	78936	19941001	19970930	7893
B	1	78937	19941001	19970930	7893
B	1	78939	19941001	19970930	7893
B	1	78940	19941001	19970930	7894
B	1	78941	19941001	19970930	7894
B	1	78942	19941001	19970930	7894
B	1	78943	19941001	19970930	7894
B	1	78944	19941001	19970930	7894
B	1	78945	19941001	19970930	7894
B	1	78946	19941001	19970930	7894
B	1	78947	19941001	19970930	7894
B	1	78949	19941001	19970930	7894
B	1	78960	19941001	19970930	7890
B	1	78961	19941001	19970930	7890
B	1	78962	19941001	19970930	7890
B	1	78963	19941001	19970930	7890
B	1	78964	19941001	19970930	7890
B	1	78965	19941001	19970930	7890
B	1	78966	19941001	19970930	7890
B	1	78967	19941001	19970930	7890

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	78969	19941001	19970930	7890
B	1	7909	19871001	19930930	79099
B	1	79094	19971001	22991231	79099
B	1	79571	19941001	19970930	7957
B	1	79579	19941001	19970930	7957
B	1	7965	19971001	22991231	7969
B	1	9095	19941001	19970930	9099
B	1	92231	19961001	19970930	9223
B	1	92232	19961001	19970930	9223
B	1	92233	19961001	19970930	9223
B	1	925	19871001	19930930	9251
B	1	95901	19971001	22991231	9590
B	1	95909	19971001	22991231	9590
B	1	96561	19981001	19990514	9656
B	1	96569	19981001	19990514	9656
B	1	98981	19951001	19970930	9898
B	1	98982	19951001	19970930	9898
B	1	98983	19951001	19970930	9898
B	1	98984	19951001	19970930	9898
B	1	98989	19951001	19970930	9898
B	1	99550	19961001	19970930	9955
B	1	99551	19961001	19970930	9955
B	1	99552	19961001	19970930	9955
B	1	99553	19961001	19970930	9955
B	1	99554	19961001	19970930	9955
B	1	99555	19961001	19970930	9955
B	1	99559	19961001	19970930	9955
B	1	99580	19961001	19970930	99581
B	1	99582	19961001	19970930	99581
B	1	99583	19961001	19970930	99581
B	1	99584	19961001	19970930	99581
B	1	99585	19961001	19970930	99581

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	99586	19981001	19990514	99589
B	1	99604	19941001	19970930	99601
B	1	99655	19981001	19990514	99652
B	1	99656	19981001	19990514	99659
B	1	9966	19871001	19890930	99669
B	1	99668	19981001	19990514	99669
B	1	9967	19871001	19890930	99679
B	1	99700	19951001	19970930	9970
B	1	99701	19951001	19970930	9970
B	1	99702	19951001	19970930	9970
B	1	99709	19951001	19970930	9970
B	1	99791	19951001	19970930	9979
B	1	99799	19951001	19970930	9979
B	1	99811	19961001	19970930	9981
B	1	99812	19961001	19970930	9981
B	1	99813	19961001	19970930	9988
B	1	99851	19961001	19970930	9985
B	1	99859	19961001	19970930	9985
B	1	99881	19941001	19970930	9988
B	1	99882	19941001	19970930	9988
B	1	99883	19961001	19970930	9988
B	1	99889	19941001	19970930	9988
B	1	E8548	19951001	19970930	E8588
B	1	E8694	19941001	19970930	E8698
B	1	E8801	19951001	19970930	E8849
B	1	E8843	19951001	19970930	E8842
B	1	E8844	19951001	19970930	E8842
B	1	E8845	19951001	19970930	E8849
B	1	E8846	19951001	19970930	E8849
B	1	E9065	19951001	19970930	E9063
B	1	E9080	19951001	19970930	E908
B	1	E9081	19951001	19970930	E908

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	E9082	19951001	19970930	E908
B	1	E9083	19951001	19970930	E908
B	1	E9084	19951001	19970930	E908
B	1	E9088	19951001	19970930	E908
B	1	E9089	19951001	19970930	E908
B	1	E9090	19951001	19970930	E909
B	1	E9091	19951001	19970930	E909
B	1	E9092	19951001	19970930	E909
B	1	E9093	19951001	19970930	E909
B	1	E9094	19951001	19970930	E909
B	1	E9098	19951001	19970930	E909
B	1	E9099	19951001	19970930	E909
B	1	E9205	19951001	19970930	E9204
B	1	E9224	19971001	22991231	E9179
B	1	E9242	19951001	19970930	E9240
B	1	E9556	19971001	22991231	E9559
B	1	E9672	19961001	19970930	E9670
B	1	E9673	19961001	19970930	E9671
B	1	E9674	19961001	19970930	E9671
B	1	E9675	19961001	19970930	E9671
B	1	E9676	19961001	19970930	E9671
B	1	E9677	19961001	19970930	E9671
B	1	E9678	19961001	19970930	E9671
B	1	E9685	19951001	19970930	E9688
B	1	E9686	19971001	22991231	E9688
B	1	E9856	19971001	22991231	E9854
B	1	V0251	19981001	19990514	V025
B	1	V0252	19981001	19990514	V025
B	1	V0259	19981001	19990514	V025
B	1	V0260	19971001	22991231	V026
B	1	V0261	19971001	22991231	V026
B	1	V0262	19971001	22991231	V026

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	V0269	19971001	22991231	V026
B	1	V0381	19941001	19970930	V038
B	1	V0382	19941001	19970930	V038
B	1	V0389	19941001	19970930	V038
B	1	V065	19941001	19970930	V068
B	1	V066	19941001	19970930	V068
B	1	V0731	19941001	19970930	V073
B	1	V0739	19941001	19970930	V073
B	1	V08	19941001	19970930	7958
B	1	V1048	19981001	19990514	V1049
B	1	V1200	19941001	19970930	V120
B	1	V1201	19941001	19970930	V120
B	1	V1202	19941001	19970930	V120
B	1	V1203	19941001	19970930	V120
B	1	V1209	19941001	19970930	V120
B	1	V1240	19971001	22991231	V124
B	1	V1241	19971001	22991231	V124
B	1	V1249	19971001	22991231	V124
B	1	V1250	19951001	19970930	V125
B	1	V1251	19951001	19970930	V125
B	1	V1252	19951001	19970930	V125
B	1	V1259	19951001	19970930	V125
B	1	V1270	19941001	19970930	V127
B	1	V1271	19941001	19970930	V127
B	1	V1272	19941001	19970930	V127
B	1	V1279	19941001	19970930	V127
B	1	V1300	19941001	19970930	V130
B	1	V1301	19941001	19970930	V130
B	1	V1309	19941001	19970930	V130
B	1	V1361	19981001	19990514	V136
B	1	V1369	19981001	19990514	V136
B	1	V1541	19961001	19970930	V154

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	V1542	19961001	19970930	V154
B	1	V1549	19961001	19970930	V154
B	1	V1582	19941001	19970930	V1589
B	1	V1584	19951001	19970930	V1589
B	1	V1585	19951001	19970930	V1589
B	1	V1586	19951001	19970930	V1589
B	1	V1640	19971001	22991231	V164
B	1	V1641	19971001	22991231	V164
B	1	V1642	19971001	22991231	V164
B	1	V1643	19971001	22991231	V164
B	1	V1649	19971001	22991231	V164
B	1	V1651	19981001	19990514	V165
B	1	V1659	19981001	19990514	V165
B	1	V1861	19981001	19990514	V186
B	1	V1869	19981001	19990514	V186
B	1	V2381	19981001	19990514	V238
B	1	V2382	19981001	19990514	V238
B	1	V2383	19981001	19990514	V238
B	1	V2384	19981001	19990514	V238
B	1	V2389	19981001	19990514	V238
B	1	V2651	19981001	19990514	V268
B	1	V2652	19981001	19990514	V268
B	1	V286	19971001	22991231	V288
B	1	V292	19941001	19970930	V298
B	1	V293	19981001	19990514	V298
B	1	V300	19871001	19890930	V3000
B	1	V310	19871001	19890930	V3100
B	1	V320	19871001	19890930	V3200
B	1	V330	19871001	19890930	V3300
B	1	V340	19871001	19890930	V3400
B	1	V350	19871001	19890930	V3500
B	1	V360	19871001	19890930	V3600

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	V370	19871001	19890930	V3700
B	1	V390	19871001	19890930	V3900
B	1	V4281	19971001	22991231	V428
B	1	V4282	19971001	22991231	V428
B	1	V4283	19971001	22991231	V428
B	1	V4289	19971001	22991231	V428
B	1	V4360	19941001	19970930	V436
B	1	V4361	19941001	19970930	V436
B	1	V4362	19941001	19970930	V436
B	1	V4363	19941001	19970930	V436
B	1	V4364	19941001	19970930	V436
B	1	V4365	19941001	19970930	V436
B	1	V4366	19941001	19970930	V436
B	1	V4369	19941001	19970930	V436
B	1	V4381	19951001	19970930	V438
B	1	V4382	19951001	19970930	V438
B	1	V4383	19981001	19990514	V4389
B	1	V4389	19951001	19970930	V438
B	1	V4450	19981001	19990514	V445
B	1	V4451	19981001	19990514	V445
B	1	V4452	19981001	19990514	V445
B	1	V4459	19981001	19990514	V445
B	1	V4500	19941001	19970930	V450
B	1	V4501	19941001	19970930	V450
B	1	V4502	19941001	19970930	V450
B	1	V4509	19941001	19970930	V450
B	1	V4551	19941001	19970930	V455
B	1	V4552	19941001	19970930	V455
B	1	V4559	19941001	19970930	V455
B	1	V4561	19971001	22991231	V456
B	1	V4569	19971001	22991231	V456
B	1	V4571	19971001	22991231	6118

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	V4572	19971001	22991231	56989
B	1	V4573	19971001	22991231	59389
B	1	V4582	19941001	19970930	V4589
B	1	V4583	19951001	19970930	V4589
B	1	V4960	19941001	19970930	V498
B	1	V4961	19941001	19970930	V498
B	1	V4962	19941001	19970930	V498
B	1	V4963	19941001	19970930	V498
B	1	V4964	19941001	19970930	V498
B	1	V4965	19941001	19970930	V498
B	1	V4966	19941001	19970930	V498
B	1	V4967	19941001	19970930	V498
B	1	V4970	19941001	19970930	V498
B	1	V4971	19941001	19970930	V498
B	1	V4972	19941001	19970930	V498
B	1	V4973	19941001	19970930	V498
B	1	V4974	19941001	19970930	V498
B	1	V4975	19941001	19970930	V498
B	1	V4976	19941001	19970930	V498
B	1	V4977	19941001	19970930	V498
B	1	V5041	19941001	19970930	V508
B	1	V5042	19941001	19970930	V508
B	1	V5049	19941001	19970930	V508
B	1	V5301	19971001	22991231	V530
B	1	V5302	19971001	22991231	V530
B	1	V5309	19971001	22991231	V530
B	1	V5331	19941001	19970930	V533
B	1	V5332	19941001	19970930	V533
B	1	V5339	19941001	19970930	V533
B	1	V561	19951001	19970930	V588
B	1	V562	19981001	19990514	V561
B	1	V5721	19941001	19970930	V572

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	V5722	19941001	19970930	V572
B	1	V5841	19941001	19970930	V584
B	1	V5849	19941001	19970930	V584
B	1	V5861	19951001	19970930	V6751
B	1	V5862	19981001	19990514	V5869
B	1	V5869	19951001	19970930	V6751
B	1	V5881	19941001	19970930	V588
B	1	V5882	19951001	19970930	V588
B	1	V5889	19941001	19970930	V588
B	1	V5901	19951001	19970930	V590
B	1	V5902	19951001	19970930	V590
B	1	V5909	19951001	19970930	V590
B	1	V596	19951001	19970930	V598
B	1	V6110	19961001	19970930	V611
B	1	V6111	19961001	19970930	V611
B	1	V6112	19961001	19970930	V611
B	1	V6122	19961001	19970930	V6121
B	1	V6283	19961001	19970930	V6281
B	1	V644	19971001	22991231	V643
B	1	V6540	19941001	19970930	V654
B	1	V6541	19941001	19970930	V654
B	1	V6542	19941001	19970930	V654
B	1	V6543	19941001	19970930	V654
B	1	V6544	19941001	19970930	V654
B	1	V6545	19941001	19970930	V654
B	1	V6549	19941001	19970930	V654
B	1	V667	19961001	19970930	V669
B	1	V690	19941001	19970930	V658
B	1	V691	19941001	19970930	V658
B	1	V692	19941001	19970930	V658
B	1	V693	19941001	19970930	V658
B	1	V698	19941001	19970930	V658

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	1	V699	19941001	19970930	V658
B	1	V728	19871001	19930930	V7285
B	1	V738	19871001	19930930	V7389
B	1	V739	19871001	19930930	V7399
B	1	V7610	19971001	22991231	V761
B	1	V7611	19971001	22991231	V761
B	1	V7612	19971001	22991231	V761
B	1	V7619	19971001	22991231	V761
B	1	V7644	19981001	19990514	V7649
B	1	V7645	19981001	19990514	V7649
B	2	,1005	19981001	19990514	12005
B	2	0525	19951001	19970930	397
B	2	1361	19871001	19910930	1369
B	2	1362	19871001	19910930	1369
B	2	1363	19871001	19910930	1369
B	2	293	19871001	19910930	2939
B	2	320	19871001	19890930	3209
B	2	3222	19951001	19970930	3229
B	2	3350	19951001	19970930	335
B	2	3351	19951001	19970930	335
B	2	3352	19951001	19970930	335
B	2	3405	19941001	19970930	3409
B	2	3600	19871001	19910930	3799
B	2	3606	19951001	19970930	3601
B	2	3617	19961001	19970930	3619
B	2	3631	19981001	19990514	363
B	2	3632	19981001	19990514	363
B	2	3639	19981001	19990514	363
B	2	3735	19971001	22991231	3733
B	2	3765	19951001	19970930	3762
B	2	3766	19951001	19970930	3762
B	2	3767	19981001	19990514	3762

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	2	3950	19951001	19970930	3959
B	2	3990	19961001	19970930	3959
B	2	410	19871001	19880930	4100
B	2	4104	19941001	19970930	4100
B	2	4105	19971001	22991231	4103
B	2	4106	19971001	22991231	4103
B	2	431	19871001	19890930	4319
B	2	432	19871001	19890930	4319
B	2	4612	19871001	19920930	4613
B	2	4701	19961001	19970930	470
B	2	4709	19961001	19970930	470
B	2	4711	19961001	19970930	471
B	2	4719	19961001	19970930	471
B	2	4836	19951001	19970930	4542
B	2	4866	19871001	19880930	4849
B	2	493	19871001	19890930	4939
B	2	5121	19961001	19970930	5122
B	2	5124	19961001	19970930	5123
B	2	5197	19871001	19890930	5213
B	2	522	19871001	19890930	5222
B	2	5284	19961001	19970930	9929
B	2	5285	19961001	19970930	9929
B	2	5286	19961001	19970930	9929
B	2	5291	19871001	19890930	5110
B	2	5293	19871001	19890930	5299
B	2	5294	19871001	19890930	5299
B	2	5451	19961001	19970930	545
B	2	5459	19961001	19970930	545
B	2	583	19871001	19900930	5839
B	2	5903	19961001	19970930	5902
B	2	5912	19961001	19970930	5911
B	2	5972	19951001	19970930	5979

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	2	5996	19871001	19890930	9851
B	2	6021	19951001	19970930	602
B	2	6029	19951001	19970930	602
B	2	6501	19961001	19970930	650
B	2	6509	19961001	19970930	650
B	2	6513	19961001	19970930	6512
B	2	6514	19961001	19970930	6519
B	2	6523	19961001	19970930	6521
B	2	6524	19961001	19970930	6522
B	2	6525	19961001	19970930	6529
B	2	6531	19961001	19970930	653
B	2	6539	19961001	19970930	653
B	2	6541	19961001	19970930	654
B	2	6549	19961001	19970930	654
B	2	6553	19961001	19970930	6551
B	2	6554	19961001	19970930	6552
B	2	6563	19961001	19970930	6561
B	2	6564	19961001	19970930	6562
B	2	6574	19961001	19970930	6571
B	2	6575	19961001	19970930	6572
B	2	6576	19961001	19970930	6573
B	2	6581	19961001	19970930	658
B	2	6589	19961001	19970930	658
B	2	660	19871001	19920930	6601
B	2	6823	19961001	19970930	6829
B	2	6851	19961001	19970930	685
B	2	6859	19961001	19970930	685
B	2	6911	19871001	19920930	743
B	2	7537	19981001	19990514	9929
B	2	7810	19871001	19910930	7710
B	2	7811	19871001	19910930	7711
B	2	7812	19871001	19910930	7712

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	2	7813	19871001	19910930	7713
B	2	7814	19871001	19910930	7864
B	2	7815	19871001	19910930	7715
B	2	7816	19871001	19910930	7716
B	2	7817	19871001	19910930	7717
B	2	7818	19871001	19910930	7718
B	2	7819	19871001	19910930	7710
B	2	7820	19871001	19910930	7710
B	2	7822	19871001	19910930	7712
B	2	7823	19871001	19910930	7713
B	2	7825	19871001	19910930	7715
B	2	7827	19871001	19910930	7717
B	2	7829	19871001	19910930	7710
B	2	7831	19871001	19910930	7841
B	2	8118	19871001	19890930	7758
B	2	8131	19871001	19890930	8157
B	2	8139	19871001	19890930	8157
B	2	8141	19871001	19890930	8154
B	2	8148	19871001	19890930	8156
B	2	8159	19871001	19890930	8151
B	2	8161	19871001	19890930	8152
B	2	8162	19871001	19890930	8152
B	2	8163	19871001	19890930	8151
B	2	8164	19871001	19890930	8151
B	2	8169	19871001	19890930	8140
B	2	8186	19871001	19890930	8174
B	2	8187	19871001	19890930	8174
B	2	8667	19981001	19990514	8665
B	2	8899	19871001	19890930	8897
B	2	8949	19871001	19920930	8945
B	2	923	19951001	19970930	0159
B	2	9230	19981001	19990514	923

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
B	2	9231	19981001	19990514	923
B	2	9232	19981001	19990514	923
B	2	9233	19981001	19990514	923
B	2	9239	19981001	19990514	923
B	2	9392	19871001	19910930	9670
B	2	9629	19981001	19990514	9639
B	2	9900	19951001	19970930	9902
B	2	9910	19981001	19990514	9929
B	2	9920	19981001	19990514	9929
B	2	9928	19941001	19970930	9925
E	1	0074	19990515	22991231	0078
E	1	0312	19990515	22991231	0318
E	1	03810	19990515	22991231	0381
E	1	03811	19990515	22991231	0381
E	1	03819	19990515	22991231	0381
E	1	27540	19990515	22991231	2754
E	1	27541	19990515	22991231	2754
E	1	27542	19990515	22991231	2754
E	1	27549	19990515	22991231	2754
E	1	3373	19990515	22991231	33729
E	1	4380	19990515	22991231	438
E	1	43810	19990515	22991231	438
E	1	43811	19990515	22991231	438
E	1	43812	19990515	22991231	438
E	1	43819	19990515	22991231	438
E	1	43820	19990515	22991231	438
E	1	43821	19990515	22991231	438
E	1	43822	19990515	22991231	438
E	1	43830	19990515	22991231	438
E	1	43831	19990515	22991231	438
E	1	43832	19990515	22991231	438
E	1	43840	19990515	22991231	438

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
E	1	43841	19990515	22991231	438
E	1	43842	19990515	22991231	438
E	1	43850	19990515	22991231	438
E	1	43851	19990515	22991231	438
E	1	43852	19990515	22991231	438
E	1	43853	19990515	22991231	43852
E	1	43881	19990515	22991231	438
E	1	43882	19990515	22991231	438
E	1	43889	19990515	22991231	438
E	1	4389	19990515	22991231	438
E	1	4588	19990515	22991231	4589
E	1	47400	19990515	22991231	4740
E	1	47401	19990515	22991231	4740
E	1	47402	19990515	22991231	4740
E	1	48240	19990515	22991231	4824
E	1	48241	19990515	22991231	4824
E	1	48249	19990515	22991231	4824
E	1	48284	19990515	22991231	48283
E	1	5186	19990515	22991231	51889
E	1	51883	19990515	22991231	51881
E	1	51884	19990515	22991231	51881
E	1	51900	19990515	22991231	5190
E	1	51901	19990515	22991231	5190
E	1	51902	19990515	22991231	5190
E	1	51909	19990515	22991231	5190
E	1	53640	19990515	22991231	9974
E	1	53641	19990515	22991231	9974
E	1	53642	19990515	22991231	9974
E	1	53649	19990515	22991231	9974
E	1	56481	19990515	22991231	5648
E	1	56489	19990515	22991231	5648
E	1	56962	19990515	22991231	56969

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
E	1	65570	19990515	22991231	65580
E	1	65571	19990515	22991231	65581
E	1	65573	19990515	22991231	65583
E	1	65970	19990515	22991231	65630
E	1	65971	19990515	22991231	65631
E	1	65973	19990515	22991231	65633
E	1	68600	19990515	22991231	6860
E	1	68601	19990515	22991231	6860
E	1	68609	19990515	22991231	6860
E	1	75670	19990515	22991231	7567
E	1	75671	19990515	22991231	7567
E	1	75679	19990515	22991231	7567
E	1	76381	19990515	22991231	7638
E	1	76382	19990515	22991231	7638
E	1	76383	19990515	22991231	7638
E	1	76389	19990515	22991231	7638
E	1	78031	19990515	22991231	7803
E	1	78039	19990515	22991231	7803
E	1	78071	19990515	22991231	7807
E	1	78079	19990515	22991231	7807
E	1	78603	19990515	22991231	78609
E	1	78604	19990515	22991231	78609
E	1	78605	19990515	22991231	78609
E	1	78606	19990515	22991231	78609
E	1	78607	19990515	22991231	78609
E	1	79094	19990515	22991231	79099
E	1	7965	19990515	22991231	7969
E	1	95901	19990515	22991231	9590
E	1	95909	19990515	22991231	9590
E	1	96561	19990515	22991231	9656
E	1	96569	19990515	22991231	9656
E	1	99586	19990515	22991231	99589

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
E	1	99655	19990515	22991231	99652
E	1	99656	19990515	22991231	99659
E	1	99668	19990515	22991231	99669
E	1	E9224	19990515	22991231	E9179
E	1	E9556	19990515	22991231	E9559
E	1	E9686	19990515	22991231	E9688
E	1	E9856	19990515	22991231	E9854
E	1	V0251	19990515	22991231	V025
E	1	V0252	19990515	22991231	V025
E	1	V0259	19990515	22991231	V025
E	1	V0260	19990515	22991231	V026
E	1	V0261	19990515	22991231	V026
E	1	V0262	19990515	22991231	V026
E	1	V0269	19990515	22991231	V026
E	1	V1048	19990515	22991231	V1049
E	1	V1240	19990515	22991231	V124
E	1	V1241	19990515	22991231	V124
E	1	V1249	19990515	22991231	V124
E	1	V1361	19990515	22991231	V136
E	1	V1369	19990515	22991231	V136
E	1	V1640	19990515	22991231	V164
E	1	V1641	19990515	22991231	V164
E	1	V1642	19990515	22991231	V164
E	1	V1643	19990515	22991231	V164
E	1	V1649	19990515	22991231	V164
E	1	V1651	19990515	22991231	V165
E	1	V1659	19990515	22991231	V165
E	1	V1861	19990515	22991231	V186
E	1	V1869	19990515	22991231	V186
E	1	V2381	19990515	22991231	V238
E	1	V2382	19990515	22991231	V238
E	1	V2383	19990515	22991231	V238

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
E	1	V2384	19990515	22991231	V238
E	1	V2389	19990515	22991231	V238
E	1	V2651	19990515	22991231	V268
E	1	V2652	19990515	22991231	V268
E	1	V286	19990515	22991231	V288
E	1	V293	19990515	22991231	V298
E	1	V4281	19990515	22991231	V428
E	1	V4282	19990515	22991231	V428
E	1	V4283	19990515	22991231	V428
E	1	V4289	19990515	22991231	V428
E	1	V4383	19990515	22991231	V4389
E	1	V4450	19990515	22991231	V445
E	1	V4451	19990515	22991231	V445
E	1	V4452	19990515	22991231	V445
E	1	V4459	19990515	22991231	V445
E	1	V4561	19990515	22991231	V456
E	1	V4569	19990515	22991231	V456
E	1	V4571	19990515	22991231	6118
E	1	V4572	19990515	22991231	56989
E	1	V4573	19990515	22991231	59389
E	1	V5301	19990515	22991231	V530
E	1	V5302	19990515	22991231	V530
E	1	V5309	19990515	22991231	V530
E	1	V562	19990515	22991231	V561
E	1	V5862	19990515	22991231	V5869
E	1	V644	19990515	22991231	V643
E	1	V7610	19990515	22991231	V761
E	1	V7611	19990515	22991231	V761
E	1	V7612	19990515	22991231	V761
E	1	V7619	19990515	22991231	V761
E	1	V7644	19990515	22991231	V7649
E	1	V7645	19990515	22991231	V7649

Table 33.1 – T_DRG_MAPPER

Grouper Version 11.0 (B) / 14.1 (E)	Diagnosis (1) / Procedure (2) Indicator	Code Billed on Claim	Effective Date	End Date	Code Used for Grouping
E	2	3631	19990515	22991231	363
E	2	3632	19990515	22991231	363
E	2	3639	19990515	22991231	363
E	2	3735	19990515	22991231	3733
E	2	3767	19990515	22991231	3762
E	2	4105	19990515	22991231	4103
E	2	4106	19990515	22991231	4103
E	2	7537	19990515	22991231	9929
E	2	8667	19990515	22991231	8665
E	2	9230	19990515	22991231	923
E	2	9231	19990515	22991231	923
E	2	9232	19990515	22991231	923
E	2	9233	19990515	22991231	923
E	2	9239	19990515	22991231	923
E	2	9629	19990515	22991231	9639
E	2	9910	19990515	22991231	9929
E	2	9920	19990515	22991231	9929

Section 34: Drug Category Code

T_DRUG_CAT_CODE Table

PURPOSE

Descriptions provided by First Data Bank for the various types of drugs listed in Indiana*AIM*.

Table 34.1 – T_DRUG_CAT_CODE

Code	Description
0	Unspecified
A	Anti-Anxiety Agents
B	Fertility Agents
C	Contraceptives, Oral
D	Diagnostics
E	Floride Preparations (Excluding Vitamin Combinations)
F	Antiobesity Drugs
G	Antacids
H	Hematinics
I	Insulins
J	Smoking Deterrents
K	Aids Related Drugs
M	Reusable Needles (All)
N	Disposable Needles (All)
O	Reusable Syringes W/WO Needles (Non-Insulin)
P	Disposable Syringes W/WO Needles (Non-Insulin)
Q	Reusable Syringes W/WO Needles (Insulin)
R	Disposable Syringes W/WO Needles (Insulin)
S	Diabetic Supplies, Miscellaneous
T	Contraceptives, Topical
U	Products Used for Approved or Unapproved
V	Vitamins
W	Contraceptives, Implantable
Y	Ostomy Supplies

Section 35: Drug Classification

T_DRUG_CLASS Table

PURPOSE

Categorizes drugs into various classifications to be used for restriction editing and pricing.

Table 35.1 – T_DRUG_CLASS

Code	Description
	No Classification
1	Class 1a
A	Anorexic
C	Smoking Cessation
E	Fertility Enhancement
F	Family Planning
I	Insulin
M	Minoxidil
N	Nutritional
P	Norplant
S	Supply
V	Vaccine
X	State Assigned

Section 36: Empty Bed Code

T_RE_EMPTY_BED Table

PURPOSE

If the prior residence of a member was out-of-state, then the claim should have an empty bed indicator to show why the facility accepted an out of state patient.

Table 36.1 – T_RE_EMPTY_BED

Indicator	Description
A	Recipient solely requires empty bed
B	Recipient desires to become Indiana resident
C	Uncertain

Section 37: Expenditure Payee Type

T_EXPENDITURE_TYPE Table

PURPOSE

List the valid types of payees to which a non-claim specific payout can be made.

Table 37.1 – T_EXPENDITURE_TYPE

Code	Description
C	TPL Carrier
O	Other
P	Provider
R	Recipient
Y	County

Section 38: Expenditure Reason Code

T_EXPENDITURE_RSN Table

PURPOSE

Lists the valid types of non-claim specific payouts and whether they are through manual or system checks and whether they require an A/R to be established.

Table 38.1 – T_EXPENDITURE_RSN

Reason Code	Description
8300	SYSTEM GENERATE
8301	MANUAL CHECK
8302	OVER REFND SYS
8303	OVER REFND MAN
8304	ADVANCE SYS
8305	CHECK ADVANCE
8306	CK FOR PREV ADJ
8307	STOPPAY APL A/R
8319	QI-2 BUY-IN PAY
8321	HIPP SYS
8322	HIPP MAN
8323	TPL HEALTH SYS
8324	TPL HEALTH MAN
8325	TPL CASUAL SYS
8326	TPL CASUAL MAN
8327	TPL/H OREF SYS
8328	TPL/H OREF MAN
8329	TPL/C OREF SYS
8330	TPL/C OREF MAN
8331	OUTSIDE AIM MAN
8332	OUTSIDE AIM SYS
8335	CONV ADM FEE M
8336	INT BEFORE 2/14

Section 39: Home Health Overhead Fee

T_OVERHEAD_FEE Table

PURPOSE

Lists the valid overhead occurrence codes and associated fees for home health overhead.

Table 39.1 – T_OVERHEAD_FEE

Occurrence Code	Effective Date	End Date	Amount
61	19950701	19961231	26.72
61	19970101	19971231	27.52
61	19980101	19981231	22.96
61	19990101	19991231	22
61	20000101	22991231	21.29
62	19950701	19961231	26.72
62	19970101	19971231	27.52
62	19980101	19981231	22.96
62	19990101	19991231	22
62	20000101	22991231	21.29
63	19950701	19961231	26.72
63	19970101	19971231	27.52
63	19980101	19981231	22.96
63	19990101	19991231	22
63	20000101	22991231	21.29
64	19950701	19961231	26.72
64	19970101	19971231	27.52
64	19980101	19981231	22.96
64	19990101	19991231	22
64	20000101	22991231	21.29
65	19950701	19961231	26.72
65	19970101	19971231	27.52
65	19980101	19981231	22.96
65	19990101	19991231	22
65	20000101	22991231	21.29

Table 39.1 – T_OVERHEAD_FEE

Occurrence Code	Effective Date	End Date	Amount
66	19950701	19961231	26.72
66	19970101	19971231	27.52
66	19980101	19981231	22.96
66	19990101	19991231	22
66	20000101	22991231	21.29

Section 40: HIB Source Codes

T_CDE_HIB_SOURCE Table

PURPOSE

Lists the originating source of a member's HIB.

Table 40.1 – T_CDE_HIB_SOURCE

Indicator	Source
H	HCFA
I	ICES
S	STATE

Section 41: HIPP Reason Codes

T_HIPP_RSN_CODES Table

PURPOSE

Lists the status codes of a member's private pay policy.

Table 41.1 – T_HIPP_RSN_CODES

Code	Description	Private Policy Purchased
1	NOT COST EFFECTIVE	N
2	PAY PREMIUM	Y
3	DIAGNOSIS NOT COVERED	N
4	NON-COVERED SERVICES	N
5	ANNUAL MAX MET	N
6	LIFETIME MAX MET	N
7	PRE-EXISTING CONDITION EXCLUDED	N
8	MEDICARE QUALIFIED	N
9	MCO QUALIFIED	N
10	PENDING VERIFICATION	P
11	OTHER	O

Section 42: ICD9 Procedure Type

T_PROC_ICD9_TYPE Table

PURPOSE

Lists the types of ICD-9 procedure codes used by the Reference subsystem. These groupings of the same type procedure codes are used in editing to streamline the process.

Table 42.1 – T_PROC_ICD9_TYPE

Code	Description
1	Unknown codes
2	PAS Exception Codes
3	PAS Surgery Codes
4	Abortion
8	Sterilization MAR/MSIS
9	Abortion MAR/MSIS
10	Family Planning MAR/MSIS

Section 43: ICES Marital Status

T_ICES_MARITAL Table

PURPOSE

Lists the valid marital statuses passed from the ICES and the cross-reference to the *AIM* code. Refer to the marital status table for more information.

Table 43.1 – T_ICES_MARITAL

ICES Code	AIM Code
?	X
DI	D
LS	T
MA	M
SE	T
SI	S
SM	T
WI	W
X	X

Section 44: ID Issue Reason

T_ID_ISSUE_RSN Table

PURPOSE

Lists the reasons an ID card can be requested as a reissue.

Table 44.1 – T_ID_ISSUE_RSN

Reason	Description
C	CHANGE
D	DAMAGED
L	LOST
R	RE-ENROLL
S	STOLEN
Y	NEW

Section 45: Lien Reason Code

T_LIEN_RSN_CODE Table

PURPOSE

Lists the valid reasons a lien could be ordered for a provider.

Table 45.1 – T_LIEN_RSN_CODE

Code	Description
8500	COURT ORDERD LIEN E
8501	IRS LEVY EST
8502	OTHER LEGAL ENTITY
8503	BACKUP WITHHOLDING

Section 46: Lien Status

T_LIEN_STATUS Table

PURPOSE

Lists the valid codes for a lien status.

Table 46.1 – T_LIEN_STATUS

Code	Description
C	CLOSED
O	OPEN

Section 47: LOC Start Reason Code 1

T_RE_LOC_STRT1 Table

PURPOSE

Lists the valid start codes for a member Level of Care segment.

Table 47.1 – T_RE_LOC_STRT!

Code	Start Reason Description
5	HOSPICE ENROLLMENT
A	PAS CASE (PAS COMPLETED – NEW ADMISSION)
B	LOC CHANGE REQUEST FROM FACILITY
C	LOC REVIEW TEAM TRANSFER
D	FACILITY REQUESTS CONTINUED LOC
E	CHANGE OF FACILITY (SAME LOC; TERMINATED 10/01/98)
F	RE-ADMISSION (SAME LOC; TERMINATED 10/01/98) FROM HOSPITAL
G	CHANGE TO LESSER LOC FOLLOWING TEMP APPROVED SKILLED AIDS/NF LOC
H	LOC REVIEW AT TIME OF MEDICAID ELIGIBILITY (EFFECTIVE DATE AFTER ADMISSION)
I	ICF/MR ADMISSION
J	HCBS WAIVER ADMISSION/CONTINUED CARE
K	CONTINUED UNDER APPEAL PROCESS/APPEAL DECISION
L	RECONSIDERATION FROM ADDITIONAL INFORMATION
M	MCO COVERAGE-SHORT TERM
N	PAS(1 YEAR PENALTY OR LATE PAS PENALTY)-INCLUDING PASARR PENALTY
P	"PASARR" NURSING FACILITY ADMISSION REQUEST
Q	INCOMPLETE PAS CASE(DSCH FROM FAC PRIOR TO COMPLETION OF PAS)-INCLUDING PASARR
R	REHAB ADMISSION TO FACILITY; TERMINATED 10/01/98
S	CHANGE OF FACILITY; TERMINATED 10/01/98
T	RE-ADMISSION; TERMINATED 10/01/98
U	ADMISSION TO FACILITY FROM HCBS WAIVER
V	MEDICAID COVERAGE FOLLOWING MEDICARE SERVICES
X	MEDICAID COVERAGE FOLLOWING VA OR OTHER COVERAGE

Table 47.1 – T_RE_LOC_STRT!

Code	Start Reason Description
Z	CONVERSION/DEFAULT

Section 48: LOC Start Reason Code 2

T_RE_LOC_STRT2 Table

PURPOSE

List the valid start codes for a member Level of Care segment.

Table 48.1 – T_RE_LOC_STRT2

Code	Start Reason II Description
00	EMPTY CODE (ALSO FOR HCBS WAIVER)
01	APPROVED-NF
02	APPROVED-INTERMEDIATE; TERMINATED 10/01/98
03	APPROVED-SKILLED; TERMINATED 10/01/98
04	APPROVED-INSTABILITY/SKILLED OBSERVATION; TERM 10/01/98
05	APPROVED-REHABILITATION(SKILLED); TERMINATED 10/01/98
06	DENIED-NO NF LEVEL OF CARE
07	DENIED-INTERM AIDS/NF REQUEST-APPROVE/CONT SKILLED AIDS/NF
08	DENIED SKILLED AIDS/NF REQUEST-NO LOC
09	DENIED SKILLED AIDS/NF REQ-APPROVE CONT INTERMEDIATE AIDS/NF
10	DENIED - DOES NOT MEET ICF/MR LEVEL OF CARE CRITERIA
11	RECIPIENT UPHELD IN APPEAL DECISION
12	DENIED SKILLED REQ-APPROVE INTERM TTL BODY CARE;TERM 10/1/98
13	DENIED-NURSING FACILITY FAILURE TO OBTAIN PAS
14	APPROVED MEDICARE SKILLED COVERED DAYS; TERMINATED 10/01/98
15	APPROVED SKILLED AIDS; DATE LATER THAN REQUESTED
1H	New Enrollment
20	APPROVED - ICF/MR (DEFAULT)
21	APPROVED - STATE OPERATED FACILITY (ICF/MR)
22	APPROVED - LARGE PRIVATE ICF/MR
23	APPROVED - BASIC DEVELOPMENTAL ICF/MR
24	APPROVED - CHILD REARING WITH BEHAVIORAL MGMT ICF/MR
25	APPROVED - CHILD REARING ICF/MR
26	APPROVED INTENSIVE TRAINING ICF/MR
27	APPROVED - SHELTERED ICF/MR

Table 48.1 – T_RE_LOC_STRT2

Code	Start Reason II Description
28	APPROVED - INTENSIVE TRAINING WITH BEHAVIOR MGMT ICF/MR
2H	Re-Election
30	APPROVED-PASARR EXEMPTED HOSPITAL DISCHARGE TO NF
31	APPROVED-PASARR EXMPT HOSP DSCH TO NF SKILLED; TERM 10/01/98
32	APPROVED-PASARR RESPITE SHORT-TERM
33	APPROVED-PASARR RESPITE SHORT-TERM SKILLED AIDS;TERM 10/1/98
34	APPROVED-PASARR ADULT PROTECTIVE SVCS 7-DAY
35	APPROVED-PASARR ADULT PROT SVCS 7-DAY SKILL AID;TERM 10/1/98
36	DENIED - PASARR EXEMPTED HOSPITAL DISCHARGE TO NF
37	DENIED - PASARR RESPITE SHORT-TERM
38	DENIED - PASARR ADULT PROTECTIVE SERVICES
39	DENIED - GENERAL PASARR ADMISSION REQUEST
3H	Re-Enrollment
41	DENY SKILL AIDS/NF-APPR INTERM AIDS/NF-PASARR EXMPT HOSP D/C
42	DENY SKILLED AIDS/NF-APPROVE INTERM AIDS/NF-PASARR RESPITE
43	DENY SKILLED AIDS/NF-APPROVE INTERM AIDS/NF-PASARR APS(7DAY)
44	DENY SKILLED AIDS/NF-APPROVE INTERM AIDS/NF-PASARR SHRT TERM
45	APPROVE-PASARR-GENERAL SHORT-TERM ADM
46	APPROVE-PASARR GENERAL SHORT-TERM SKILL PROCED;TERM 10/1/98
47	APPROVE-PASARR GEN SHORT-TERM SKILLD-INSTAB/OBS;TERM 10/1/98
48	APPROVE-PASARR GENERAL SHORT-TERM SKILLED-REHAB;TERM 10/1/98
4H	Transfer
50	CASE MIX CONVERSION; EFFECTIVE 10/01/98
60	APPROVED-EXTENSIVE CARE-REHABILITATION; TERMINATED 10/01/98
61	APPROVED-EXTENSIVE CARE-TRACH CARE; TERMINATED 10/01/98
62	APPROVED-EXTENSIVE CARE-RESPIRATORY THERAPY; TERM 10/01/98
63	APPROVED-EXTENSIVE CARE/VENT CARE; TERMINATED 10/01/98
64	APPROVED-VENT CARE RATE; TERMINATED 10/01/98
65	DENIED EXT CARE/VENT RQST-APPROVED/CONT INTERM;TERM 10/1/98
66	DENIED EXT CARE/VENT RQST-APPROVED/CONT SKILLED;TERM 10/1/98

Table 48.1 – T_RE_LOC_STRT2

Code	Start Reason II Description
67	DENIED EXT CARE/VENT INSTABILITY/SKILLD OBSERV;TERM `10/1/98
68	DENIED EXT CARE VENT RQST-APPROVE REHAB SKILLED;TERM 10/1/98
80	TRANSFER OF PROPERTY PENALTY ENDED
81	TRANSFER OF PROPERTY PENALTY APPEALED
82	TRANSFER OF PROPERTY PENALTY NOT ELIGIBLE FOR LTC

Section 49: LOC Stop Reason Code 1

T_RE_LOC_STOP1 Table

PURPOSE

Lists the valid stop reasons for a member Level of Care segment.

Table 49.1 – T_RE_LOC_STOP1

Code	LOC Stop1 Description
5	Hospice Stop Reasons
A	Conversion/Default
B	Automatic Stop - UB92 Claim Discharge
F	Reconsideration /appeal-State decision upheld
G	Reconsideration/appeal requested
H	Denied-No LOC
I	End of current denial/appeal perd of ineligibility
J	Replacement facility (ICF/MR Provider Moved)
K	Other Payor Source Begins/Ends; Effective 10/01/98
L	Transfer from facility to facility
M	MCO Recipient
N	Automatic Stop - No Claim Activity
O	LOC review recommended transfer (I to S or S to I)
P	LOC review team recommended discharge (No LOC)
Q	Transfer from facility to waiver case
R	Waiver Case-no longer eligible
S	No longer meets LOC criteria
T	PASARR-Other(active treatment needs)
U	PASARR-Short-term Stay(Respite, other short-term)
V	AIDS/NF LOC Change Request from Facility
W	End of Temporary LOC - Rescreen
X	Discharge from Facility
Y	Death
Z	Termination of Medicaid Elibibility/or Restriction

Section 50: LOC Stop Reason Code 2

T_RE_LOC_STOP2 Table

PURPOSE

Lists the valid stop reasons for a member Level of Care segment.

Table 50.1 – T_RE_LOC_STOP2

Code	LOC Stop2 Description
00	Level of Care Reason Code
01	1704 Temporary Aids/Nf Upgrade-Loc
02	Rn Requires Updated Information (Nursing Facility)
03	Qmrp Requires Updated Information (Icf/Mr)
04	End Of Waiver Short-Term Loc
05	No 450b From Nf To Start Loc
06	End Of Medicare Bed-Hold; Terminated 10/01/98
10	Readmission From Hospital/Bed-Hold Expired
11	Discharge To Community
1H	Revocation
20	State Decision Upheld
21	State Rescinded On Reconsideration
22	Appellant Upheld
23	Appellant Withdrew Appeal
2H	Discharge - Non Death
30	Transfer Of Property Penalty
3H	Transfer To Another Provider
4H	Recipient Death
50	Case Mix Conversion
5H	Enrollment Period Limitation
97	No Claim Activity
98	Ub92 Claim Activity
99	AIM Stop2 Conversion Code

Section 51: Locality

T_LOCALITY Table

PURPOSE

Lists the valid types of localities used to described the geographic region of the provider's service location.

Table 51.1 – T_LOCALITY

Code	Description
01	Metropolitan
02	Urban
03	Rural
07	Out-of-State
10	County
11	City
12	Country
13	Section
99	Statewide

Section 52: Location Code

T_LOCATION Table

PURPOSE

Lists the location in the system where the claim currently resides for processing.

Table 52.1 – T_LOCATION

Code	Description
00	Validity Edits
01	Provider Related Edits
02	Recipient Related Edits
03	PA Related Edits
04	Procedure Code Related Edits
20	History Related Audits (Dup Audits)
21	Medical Policy Related Edits And Audits
22	Medical Review
23	Manual Pricing
30	Sur – Provider On Review
31	Sur – Recipient Locked In
40	CCF
41	Recycle
42	Hold
43	IFSSA
44	CSHCS
50	Adjustments
66	Claim Denied
90	Special Processing (Region Code 90)
97	Fiscal Pend
98	Claim Approved For Payment
99	Claim Adjudicated
CD	Claim Deleted(Overactivated)
CO	Claim Open(Activated, But Not Keyed)
CP	Claim Processed(Activated And Keyed)

Table 52.1 – T_LOCATION

Code	Description
PP	Production Adjustment Request Pending Release
PR	Prodution Adjustment Request Released
TP	Test Adjustment Request Pending Release

Section 53: Managed Care Reason

T_RE_MC_REASON Table

PURPOSE

Lists the reason a member has been placed in the Managed Care program for auto-assignment and their current status if no assignment was possible.

Table 53.1 – T_RE_MC_REASON

Code	Description
	Autoassignment-AA-W
A	No valid PMP choice -AA-I
B	Pending For Manual Asgnmt
C	BA Assistance Required
D	Newborn Auto Assgnmt-AA-I
E	Redet dte>30 day ago-AA-I
F	Recipient has Medicare
G	PCCM Voluntary DSNRL-AA-W
H	RBMC Voluntary DSNRL-AA-W
I	PCCM Mandatory DSNRL-AA-I
J	RBMC Mandatory DSNRL-AA-I
K	Disabled
L	RBMC DSNRL- Joins PCCM
M	RBMC DSNRL- Fee for Svc
N	RBMC DSNRL-PMP NoResponse
O	CHIPS-AA-W
P	Package C-AA-W

Section 54: Marital Status

T_CDE_MARITAL Table

PURPOSE

Lists the marital status codes in Indiana*AIM*.

Table 54.1 – T_CDE_MARITAL

Code	Description
D	Divorced
M	Married
S	Single
T	Separated
W	Widowed
X	Unknown

Section 55: Media Type

T_PA_MEDIA Table

PURPOSE

Lists the valid types of media on which a PA can be received.

Table 55.1 – T_PA_MEDIA

Code	Description
1	PAPER
2	TELEPHONE
3	FAX
4	CSHCS
5	PAS
6	PROB PA
7	PAS
8	MCO
9	INQUIRY

Section 56: Modifier Type

T_MODIFIER_TYPE Table

PURPOSE

Lists the valid modifier types and what function they perform.

Table 56.1 – T_MODIFIER_TYPE

Code	Description
1	Pricing
2	Processing
3	Informational
4	Review
5	Anesthesia
6	Med Direction
7	Physical Status
8	Emergency
9	Anesthesia Units
D	Denial

Section 57: NCPDP Response

T_NCPDP_RESPONSE Table

PURPOSE

These are the National Council on Prescription Drug Programs (NCPDP) codes that are sent back to Point of Sale (POS) pharmacy when certain edits are set. This is standard processing in a POS environment.

Table 57.1 – T_NCPDP_RESPONSE

Code	Description
05	Missing/Invalid Pharmacy Number
07	Missing/Invalid Cardholder Identification Number
15	Missing/Invalid Date Filled
16	Missing/Invalid Prescription Number
17	Missing/Invalid New-Refill Code
18	Missing/Invalid Metric Quantity
19	Missing/Invalid Days Supply
21	Missing/Invalid NDC Number
22	Missing/Invalid Dispense as Written Code
25	Missing/Invalid Prescriber Identification
28	Missing/Invalid Prescription Written
32	Missing/Invalid Level of Service
40	Pharmacy not contracted with plan on DOS
50	Non-Matched Pharmacy Number
52	Non-Matched Cardholder Identification
54	Non-Matched NDC Number
65	Patient is not covered
66	Patient age exceeds maximum age
70	NDC not covered
74	Other carrier payment meets or exceeds payable
77	Discontinued NDC number
78	Cost exceeds maximum
81	Claim is too old

Table 57.1 – T_NCPDP_RESPONSE

Code	Description
82	Claim is post-dated
83	Duplicate piad/captured claim
CA	Missing/Invalid Patient First Name
DQ	Missing/Invalid Usual and Customary
DV	Missing/Invalid Other Payor Amount
M2	Recipient locked in
M4	Prescription number/time limit exceeded
M5	Requires manual claim

Section 58: Occurrence Codes

T_OCCURRENCE Table

PURPOSE

Lists the valid occurrence codes for use on the UB-92.

Table 58.1 – T_OCCURRENCE

Code	Description
01	Auto Accident
02	No Fault Ins Involved - Includ Auto Accident/Other
03	Accident/Tort Liability
04	Accident/Employment Related
05	Other Accident
06	Crime Victim
25	Date Benefits Terminated By Primary Payer
27	Date Home Health Plan Established Or Last Reviewed
50	Previous Hospital Discharge
52	Initial Examination
51	Date Of Discharge
61	1 Overhead Per Day
62	2 Overheads Per Day
63	3 Overheads Per Day
53	Home Health Therapy
64	4 Overheads Per Day
65	5 Overheads Per Day
66	6 Overheads Per Day

Section 59: Origin Code

T_ORIGIN_CODE Table

PURPOSE

Lists the origin of a TPL policy update.

Table 59.1 – T_ORIGIN_CODE

Code	Description
A	ICES
B	Caseworker
C	FSSA
D	Recipient
E	Provider
F	Attorney
G	Insurance Company
H	Employer
I	Policyholder
J	Absent Parent
K	Black Lung
L	Other
M	Malpractice Dm
Q	Deers
R	Tortfeasor
S	State Police Dm
T	Acc/Trauma Rpt
W	Worker Comp Dm
X	HMS

Section 60: PA Line Item Status

T_PA_LINEITEM_STAT Table

PURPOSE

Lists the status of a PA line item.

Table 60.1 – T_PA_LINEITEM_STAT

Code	Description
A	Approved
B	Non-Cov Code Approve
C	Dec Overturn By Alj
D	Denied
E	Evaluation
F	Appr/Contin Of Serv
G	Mod/Contin Of Serv
H	Den/Contin Of Serv
I	Non-Cov Code Denied
K	Suspended
L	Restored Waiting App
M	Modified
N	No Pa Required
O	No Pa Req For Pmp
P	Pending
Q	Incorrect Pmp
R	Rejected
S	Dis No Hearing Appr
T	Dis No Hearing Mod
U	Dis No Hearing Den
V	Mod Thru Court
W	Dec Upheld By Alj
X	Mod Thru Admin Rev
Y	Appr Thru Admin Rev
Z	Auto Appr After 10

Section 61: PMP Assignment Reason

T_RE_PMP_REASON Table

PURPOSE

Lists the reasons a member can be assigned to a PMP.

Table 61.1 – T_RE_PMP_REASON

Code	Description	Can code be used as both open and close reason?
01	Approved Change	B
02	New Eligible	N
03	6 Month PMP change	B
04	Newborn auto-assign change	B
05	Recipient initiated – MCO disenrollment	B
06	Redetermination	B
07	Death	Y
08	Disenroll from Hoosier Healthwise	Y
09	Expired Managed Care Segment.	Y
10	PCCM Voluntary Disenroll	B
11	RBMC Voluntary Disenroll	B
12	PCCM Mandatory Disenroll	B
13	RBMC Mandatory Disenroll	B
20	Auto assigned – Newborn	B
21	Auto Assigned – Case Assignment	B
22	Auto Assigned – Previous PMP	B
23	Auto Assigned – Default	B
24	Auto Assigned – PCCM Disenrolled	B
25	Auto Assigned – RBMC Disenrolled	B
26	Auto Assigned – Newborn Preselection	B
27	MCPD – Other	Y
28	Auto Assigned – Redetermination	B
30	Voluntary county enrollment	N
31	Aprvd. Chng. - Recipient Choice Auto Assignment	B
33	Aprvd. Chng. - Untimely Communication	B

Table 61.1 – T_RE_PMP_REASON

Code	Description	Can code be used as both open and close reason?
35	Aprvd. Chng. - PMP Panel Full	N
40	Aprvd. Chng. - PCCM PMP Disenrolled	B
41	Aprvd. Chng. - RBMC PMP Disenrolled	B
42	Aprvd. Chng. - Error in Assignment	B
43	Aprvd. Chng. - MCO Ancillary Service Access Issues	B
44	Aprvd. Chng. - PCCM Ancillary Srvice Access Issues	B
45	Aprvd. Chng. - Quality of Service Issues	B
46	Aprvd. Chng. - Third Party Liability	Y
50	Aprvd. Chng. - Inconvenient Location	B
51	Aprvd. Chng. - Recipient Moved	B
52	Aprvd. Chng. - Transportation Problems	B
53	Aprvd. Chng. - Appointment Delays	B
54	Aprvd. Chng. - Waiting Time	B
55	Aprvd. Chng. - Treatment by staff	B
56	Unsatisfactory Communication	B
57	Aprvd. Chng. - Unsatisfactory quality of care	B
58	Unsatisfactory emergency response	B
59	Aprvd. Chng. - Unable to obtain referral	B
60	Aprvd. Chng. - Insufficient after-hours coverage	B
61	Aprvd. Chng. - Physician no longer Medicaid	B
62	Aprvd. Chng. - Physician no longer in practice	B
63	Aprvd. Chng. - Physician Patient rltnshp unacpt	B
64	Aprvd. Chng. - Med condition not approp to pvdr	B
65	Physician requests recip reassign	B
66	Aprvd. Chng. - Speclty not consistant with cond.	B
67	Aprvd. Chng. - Preg. related - ante-partum change	B
68	Aprvd. Chng. - Preg. related - post-partum change	B
69	Aprvd. Chng. - Other	B
70	ICES County Change	B
71	Residency Change	B
72	Third Party Liability Issues	B
73	Continuity of Care Issues	B

Table 61.1 – T_RE_PMP_REASON

Code	Description	Can code be used as both open and close reason?
74	Recipient Determined to be Illegal Alien	Y
75	Recipient Choice - Enrolled in HCBS Waiver Program	B
76	Recipient Choice - Ward or Foster Child	B
77	Network Limitations	Y
78	More than one RID # linked from ICES	B
79	Recipient in Hospice	Y
80	Recipient Ineligible Due To Age	Y
81	Eligibility was removed	Y
99	Open	Y

Section 62: Policy Type

T_POLICY_TYPE Table

PURPOSE

Lists the types of policy used in the TPL system.

Table 62.1 – T_POLICY_TYPE

Code	Description
1	Private Pay Health Insurance
2	Private Pay – HMO
3	State Paid HMO
4	HIPP – Health Insurance
5	HIPP – HMO
6	HIPP – PPO
7	Other

Section 63: Pricing Indicator

T_PRICING_IND Table

PURPOSE

Indicates what methodology is used to price a procedure code.

Table 63.1 – T_PRICING_IND

Pricing Indicator	Description
0	Normal
1	Max Fee
5	Manual
6	Manually Priced per pend
7	Manually Priced
8	Zero Paid
A	Max Fee > 940101 > Normal
B	Max Fee > 940101 > Manual
F	Flat Fee
L	Lab Fee
R	RBRVS
T	Transportation
Z	Zero Pay

Section 64: Prior Residence

T_RE_PRIOR_RES Table

PURPOSE

Indicates the prior resident of a member currently in a LTC facility.

Table 64.1 – T_RE_PRIOR_RES

Code	Description
00	INDIANA ONLY – Undefined
01	INDIANA ONLY – Home
02	INDIANA ONLY – Hospital-Acute Care
03	INDIANA ONLY – Hospital-Rehab
04	INDIANA ONLY – State Hospital
05	INDIANA ONLY – State Hospital-Psychiatric
06	INDIANA ONLY- ICF/MR (Undifferentiated)
07	INDIANA ONLY – ICF/MR (Large Private)
08	INDIANA ONLY – ICF/MR (Small Private)
09	INDIANA ONLY – Psychiatric Hospital/Unit
10	INDIANA ONLY – Nursing Facility
11	INDIANA ONLY – Residential Facility (ARCH/RBA)
12	Incarcerated
AK	Alaska
AL	Alabama
AR	Arkansas
AZ	Arizona
CA	California
CO	Colorado
CT	Connecticut
DC	Washington DC
DE	Delaware
FL	Florida
GA	Georgia
HI	Hawaii
IA	Iowa

Table 64.1 – T_RE_PRIOR_RES

Code	Description
ID	Idaho
IL	Illinois
KS	Kansas
KY	Kentucky
LA	Louisiana
MA	Massachusetts
MD	Maryland
ME	Maine
MI	Michigan
MN	Minnesota
MO	Missouri
MS	Mississippi
MT	Montana
NC	North Carolina
ND	North Dakota
NE	Nebraska
NH	New Hampshire
NJ	New Jersey
NM	New Mexico
NV	Nevada
NY	New York
OH	Ohio
OK	Oklahoma
OR	Oregon
PA	Pennsylvania
RI	Rhode Island
SC	South Carolina
SD	South Dakota
TN	Tennessee
TX	Texas
UT	Utah
VA	Virginia
VT	Vermont

Table 64.1 – T_RE_PRIOR_RES

Code	Description
WA	Washington
WI	Wisconsin
WV	West Virginia
WY	Wyoming

Section 65: Prison Facility

T_FAC_PRISON Table

PURPOSE

Lists the 590 facilities and their cities.

Table 65.1 – T_FAC_PRISON

Code	Description	City
ACC	Atterbury Correctional Center	Edinburgh
BLW	Bloomington Work Release Center	Bloomington
BTC	Branchville Training Center	Tell City
CCU	Central State Correctional Unit	Indianapolis
CHW	Craine House Work Release Center	Indianapolis
CIC	Correctional Industrial Complex	Pendleton
COA	Central Office Administration	Indianapolis
COL	Chain O Lakes Correctional Unit	Albion
ESH	Evansville State Hospitial	Evansville
EVW	Evansville Work Release Center	Evansville
FSD	Ft Wayne State Dev Ctr	Ft Wayne
FWW	Fort Wayne Work Release Center	Fort Wayne
GEN	Generic Facility	
GTC	Glenview Treatment Center	Terre Haute
HYC	Clark County Correctional Unit	Henryville
IBS	Indiana Boys' School	Plainfield
IGS	Indiana Girl's School	Indianapolis
IMW	Indianapolis Men's Work Release Center	Indianapolis
ISB	Indiana School For The Blind	Indianapolis
ISC	Indiana Soldiers And Sailors Childrens Home	Knightstown
ISD	Indiana School For The Deaf	Indianapolis
ISF	Indiana State Farm	Greencastle
ISP	Indiana State Prison	Michigan City
ISR	Indiana State Reformatory	Pendleton
IVH	Indiana Verterans Home	West Lafayette
IWI	Indiana Women's Intake	Indianapolis

Table 65.1 – T_FAC_PRISON

Code	Description	City
IWP	Indiana Women's Prison	Indianapolis
IWW	Indianapolis Women's Work Release Center	Indianapolis
IYC	Indiana Youth Center	Plainfield
JCU	Johnson Correctional Unit	Edinburgh
LCM	Larue D. Carter Memorial Hospitial	Indianapolis
LCU	Lakeside Correctional Unit	Michigan City
LSH	Logansport State Hospitial	Logansport
MCC	Maximum Control Complex	Westville
MCU	Madison Correctional Unit	Madison
MSD	Muscatatuck State Dev	Butlerville
MSH	Madison State Hospital	Madison
MYC	Medaryville Correctional Unit	Medaryville
NCS	New Castle State Hospital	New Castle
NIS	Northern In State Dev Ctr	South Bend
OTH	Other	
P4A	Evansville District Office #4a	Evansville
P4B	Terre Haute District Office #4b	Terre Haute
PD0	Central Office Parole District #0	Indianapolis
PD2	Fort Wayne District Office #2	Fort Wayne
PD3	Indianapolis District Office #3	Indianapolis
PD5	Columbus District Office #5	Columbus
PD6	Gary District Office #6	Gary
PD7	New Castle District Office #7	New Castle
PD8	South Bend District Office #8	South Bend
RCU	Richmond Correctional Unit	Indianapolis
RDC	Reception Diagnostic Center	Plainfield
RSH	Richmond State Hospital	Richmond
RSW	Riverside Residential Center	Indianapolis
RTC	Rockville Training Center	Rockville
SBW	South Bend Work Release Center	Westville
SCD	Silvercrest Childrens Development Center	New Albany
SFW	Summit Farm Work Release Center	Laporte
WCC	Westville Correctional Center	Westville

Table 65.1 – T_FAC_PRISON

Code	Description	City
WPR	Westville Pre-Release	Westville
WTU	Westville Transition Unit	Westville
WVC	Wabash Valley Correctional Institution	Carlisle
WVW	Westville Work Release Center	Westville

Section 66: Procedure Type

T_PROC_TYPE Table

PURPOSE

Lists the types of procedure codes used by the Reference subsystem. This grouping of the same type procedure codes is used in editing to streamline the process. Some edits are set against types of procedures as opposed to listing all the procedure codes in the edit.

Table 66.1 – T_PROC_TYPE

Code	Description
1	Tran Mileage
2	Tran Over 99
3	Tran Related Services
4	Tran Mileage All
5	Transportation Ambulance
6	Transportation Base Rate
7	Transportation Multi Pass
8	Transportation Delete
9	Transportation Waiting
10	Transportation Deduct
11	Transportation Copay
12	Tran Requiring PA
13	Endoscopy
14	Lab Collection Fees
15	Medical Supply Services
16	Durable Medical Equipment
17	Prosthetic/Orthotic Serv
18	Lab
19	Xray
20	Transportation Emer. Amb.
21	Transport. Non-emer. Amb.
22	Transportation Other Amb.
23	Transport. Wheelchair Van

Table 66.1 – T_PROC_TYPE

Code	Description
24	Transportation Taxi
25	Transport. Com. Amb.
26	Transport. Family Member
27	Transportation Other
28	Therapy Physical
29	Therapy Speech
30	Therapy Occupational
31	Therapy Respiratory
32	Therapy Audiology
33	Eye Care Exams
34	Eyewear Eyeglasses
35	Eyewear Contacts
36	Dialysis
37	Rendering Therapist
38	Waiver Level I
39	Waiver Level II
40	Nurse Practitioner
41	Midwives
42	High Risk Pregnancy
43	Waiver Type
44	EPSDT Screen after 9/95
45	EPSDT Screen til 9/95
46	Anesthesia
47	Care Coordination I
48	Care Coordination II
49	HIV/AIDS Case Management
50	Specific MRO Services
51	Rehab
52	Psych Test by Physician
53	Psychiatric Codes
54	Equipment and Supplies
55	DME
56	Opthalmologist Services

Table 66.1 – T_PROC_TYPE

Code	Description
57	Abortion
58	Hysterectomy
59	Sterilization
60	EPSDT1
61	EPSDT2
62	Initial Visit
63	Established Patient Visit
64	EPSDT3
65	Vascular Diagnostic Study
66	Spine or Joint X-Rays
67	Lab Services
68	Prosthetic/Orthotic- Risk
69	Therapy (Edit 4086)
70	Non-Anatomical Lab
71	Antepartum Care
72	EPSDT Compliance
73	Family Plan 1 (Edit 1011)
74	Family Plan 2 (Edit 1011)
75	Prohpylaxis
76	EPSDT Services (MARS)
77	PAS Exception
78	PAS Surgery
79	Antepartum care (1031)
80	EPSDT HCFA 416
81	EPSDT 416-VENIPUNCTURE
82	EPSDT 416-TB OR MANTOUX
83	Medicare B TPL Exempt
84	Private Ins TPL Exempt
85	Medicare A TPL Exempt
87	HH Services Exempt
88	HH Therapies Exempt
89	Champus
90	TRANSPO-EMERG. IND. =Y

Table 66.1 – T_PROC_TYPE

Code	Description
91	TRANSP-LOC = I,S,R
92	TRANSPO-POS=21
93	TRANSPO-POS=12
94	TRANSPO-BASE>20-NO PA
95	TRIPS-ACCOMPANYNG PARENTS
96	MH NO ELECTRONIC BILL TPL
97	PT NO ELECTRONIC BILING
98	ST - NO ELECTRONIC BILLIN
99	BYPASS TPL A-Z-J-G-AN-A
100	Waiver Services - MAR
101	Medicare part B Grp I
102	Group II
103	Group III
104	Emergency Department visits
105	FQHC/RHC
106	X3069 PA PROCEDURE
107	PROC GRP 106 X-WALK TO Y0601
108	90% PRICING
109	PA Ambulance Transportation Category
110	PA Commercial Ambulatory Transportation Category
111	PA Non-Ambulatory Transportation Category
112	PA Mileage Transportation Category
113	PA Emergency Ambulance Transportation Category
114	PA Interfacility Ambulance Transportation Category
115	HOSPICE/WAIVER DUPLICATIVE SVS
116	EPSDT Vaccine For Children Program
117	ANESTHESIA - MATERNITY-1Unit/15 & 1Unit/60
118	WAIVIER CLIA Codes
119	PPMP CLIA Codes
120	ALL OTHER CLIA Codes
121	Reserved for future use
122	Reserved for future use
123	Reserved for future use

Table 66.1 – T_PROC_TYPE

Code	Description
124	Reserved for future use
125	Reserved for future use
126	Package C Transportation Services Requiring Copay
127	Aged and Disabled Waiver
128	Autism Waiver
129	ICF/MR Waiver
130	Medically Fragile Children Waiver
131	TBI Waiver
132	Package C Lifetime Procedures
133	HCPC Sterilization MAR/MSIS
134	HCPC Abortion MAR/MSIS
135	HCPC Family Planning MAR/MSIS
136	Dental Codes Requiring ONE Tooth Sfc Cde
137	Dental Codes Requiring TWO Tooth Surface Codes
138	Dental Codes Requiring THREE Tooth Surface Codes
139	Dental Codes Requiring FOUR or MORE Tooth Sfc Cds

Section 67: Provider Address Type

T_PR_ADDR_CODE Table

PURPOSE

Lists the type of address for a provider service location.

Table 67.1 – T_PR_ADDR_CODE

Code	Description
H	Home Office
M	Mail to
P	Pay to
S	Service Location

Section 68: Provider Enrollment Status

T_PR_ENROLL_STATUS Table

PURPOSE

Lists the status of a provider's enrollment in Indiana*AIM*.

Table 68.1 – T_PR_ENROLLMENT_STATUS

Code	Description
1	Suspended (MMIS)
2	Retired (MMIS)
3	Enrolled (MMIS)
4	Deceased (MMIS)
5	Corporation (MMIS)
6	Deleted (MMIS)
7	Inactive (MMIS)
8	Return Mail (MMIS)
9	New Individual (MMIS)
A	Active
B	Term. by HPB
D	Deceased
E	Recertification Date
H	Term. by HCFA
I	Term. by IFSSA
L	Duplicate Enrollment
M	Return Mail
P	Term. by Provider
R	Retired
U	Term. by not Enroll
W	Moved OOS (MMIS)
X	Decertified (MMIS)
Y	Deactivated (MMIS)
Z	Deactivated (MMIS)

Section 69: Provider Written Correspondence

T_PR_WCTS_LTR_PART Table

PURPOSE

Lists opening and closings for written correspondence inquiry letters.

Table 69.1 – T_PR_WCTS_LTR_PART

Code Letter	Number Sequence	Code Open/Close	Description
100	1	C	Please direct further questions to EDS Customer Assistance at the appropriate telephone number listed at the end of this letter. Thank you for your c
100	1	O	Thank you for your recent inquiry to the Indiana Health Coverage Programs. The answer to your inquiry follows:
100	2	C	Continued participation in the Indiana Health Coverage Programs.

Section 70: Provider Eligibility Table

T_PR_PHP_ELIG Table

PURPOSE

Lists provider number, date effective/end, and programs in which they are enrolled.

Table 70.1 – T_PR_PHP_ELIG

Provider	Program	Date Effective	Date End	Code Enroll Status
Different numbers	100006 100007 100013	Termed by enrollment	Termed by enrollment	1,2,3,4,5,6,7,89, A,B,D,E,H I,L,M,P,R,U W,X,Y,Z

Section 71: Provider Phone Type

T_PR_PHONE_TYPE Table

PURPOSE

Lists categories for the phone representatives.

Table 71.1 – T_PR_PHONE_TYPE

Code Inquiry Type	Description
1	01-Claim Status
2	02-TPL
3	03-Long Term Care
4	04 04-Check Write
5	05-Recipient Eligibility
6	06-Provider Enrollment
7	07-PA Verification
8	08-Covered Services
9	09-Remittance Advice
10	10-Crossovers
11	11-Advance Request
12	12-Accounts Receivable
13	13-Managed Care
14	14-Order Forms
15	15-HCPCS/Modifier/Diagnosis
16	16-Adjustments
17	17-Stop Pay / EFT
18	18-ECS
19	19-Transportation
20	20-Special Programs
21	21-Other
22	22-Recipient Calls
23	23-Caseworkers
26	26-Provider Holds
27	27-POS Issues
28	28-P.O. Box Info

Table 71.1 – T_PR_PHONE_TYPE

Code Inquiry Type	Description
29	29-Hangs Ups
30	30-Wrong Numbers
31	31-System Down
32	32-Keying Errors
33	33-Denial Explanation
34	34-Suspense
35	35-HCE General Questions
36	36-HCE Address
37	37-HCE Telephone Numbers
38	38-HCE Provider concerns
39	39-Att./Prov./Other Calls
40	40-REC Caseworker
41	41-REC Copays
42	42-REC Dentures/Braces
43	43-REC Dr. Referrals/Phone #
44	44-REC Dental Providers
45	45-REC Eligibility
46	46-REC Covered Services
47	47-REC Bills Received
48	48-REC Prior Authorization
49	49-REC Out of State Services
50	50-REC Waiver/Council on Aging
51	51-REC Crossovers
52	52-REC Managed Care
53	53-REC Third Party Liability
54	54-REC Spenddown
55	55-REC State Answer Line
56	56-REC Emergency Services
57	57-REC Hang-up/Wrong Number
58	58-REC Ref. Fraud and Abuse
59	59-REC Reimbursement
60	60-REC Spanish Recipient
61	61-REC Transportation

Table 71.1 – T_PR_PHONE_TYPE

Code Inquiry Type	Description
62	62-REC Special Programs
63	63-REC Other
64	64-PKG C Addr. /Tele. Num.
65	65-PKG C Check Write
66	66-PKG C Claim Status
67	67-PKG C Covered Services
68	68-PKG C Prior Auth. Ver.
69	69-PKG C Recipient Elig.
70	70-REC PKG C Caseworker
71	71-REC PKG C Co-payment Reim.
72	72-REC PKG C Covered Services
73	73-REC PKG C Elig.
74	74-REC PKG C Prem. Question
75	75-REC PKG C Prior Auth.
76	76-REC PKG C Referrals
77	77-REC PKG C Prem. Vendor Q.
78	78-Provider Manual.
79	79-Y2K.

Section 72: Provider Recipient Loc Xref

T_PR_RECP_LOC_X Table

PURPOSE

Cross-references the member's Level of Care to the provider's level of care.

Table 72.1 – T_PR_RECP_LOC_X

Member LOC	Effective Date	End Date	Provider LOC
I10	19000101	22991231	02
I11	19000101	22991231	02
I13	19981001	22991231	22
I20	19000101	22991231	03
N	19981001	22991231	20
R	19000101	19980930	08
S10	19000101	22991231	01
S11	19000101	22991231	01
S12	19000101	19980930	04
S13	19000101	22991231	11
S14	19000101	19980930	05
S15	19000101	19980930	06

Section 73: Provider Specialty

T_PR_SPEC_CDE Table

PURPOSE

Lists all provider specialties in specialty number order.

Table 73.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
010	Acute Care	N
011	Psychiatric	N
012	Rehabilitation	N
020	Ambulatory Surgical Center (ASC)	N
030	Nursing Facility	N
031	ICF/MR	N
032	Pediatric Nursing Facility	N
033	Residential Care Facility	N
040	Rehabilitation Facility	N
050	Home Health Agency	N
060	Hospice	N
070	Risk Based Managed Care (RBMC)	N
071	Managed Care Organization (MCO)	N
072	Prepaid Health Plan (PHP)	N
073	Competitive Medical Plans (CMP)	N
080	Federally Qualified Health Clinic (FQHC)	Y
081	Rural Health Clinic (RHC)	N
082	Medical Clinic	Y
083	Family Planning Clinic	N
084	Nurse Practitioner Clinic	N
085	Title V Clinic	Y
086	Dental Clinic	N
087	Therapy Clinic	N
090	Pediatric Nurse Practitioner	N

Table 73.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
091	Obstetric Nurse Practitioner	N
092	Family Nurse Practitioner	N
093	Nurse Practitioner (Other)	N
094	Certified Registered Nurse Anesthetist (CRNA)	N
095	Certified Nurse Midwife	N
100	Physician Assistant	N
101	Anesthesiology Assistant	N
110	Outpatient Mental Health Clinic	N
111	Community Mental Health Center (CMHC)	N
112	Psychologist	N
113	Certified Psychologist	N
114	Health Service Provider in Psychology (HSPP)	N
115	Certified Clinical Social Worker	N
116	Certified Social Worker	N
117	Psychiatric Nurse	N
120	School Corporation	N
130	County Health Department	N
140	Podiatrist	N
150	Chiropractor	N
160	Registered Nurse (RN)	N
161	Licensed Practical Nurse (LPN)	N
162	Registered Nurse Clinical (RNC)	N
170	Physical Therapist	N
171	Occupational Therapist	N
172	Respiratory Therapist	N
173	Speech/Hearing Therapist	N
180	Optometrist	N
190	Optician	N
200	Audiologist	N
210	Care Coordinator for Pregnant Women	N

Table 73.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
211	HIV Case Manager	N
212	CSHCS Care Coordinator	N
220	Hearing Aid Dealer	N
230	Registered Dietitian	N
240	Pharmacist	N
250	DME/Medical Supply Dealer	N
260	Ambulance	N
261	Air Ambulance	N
262	Bus	N
263	Taxi	N
264	Common Carrier (Ambulatory)	N
265	Common Carrier (Non-ambulatory)	N
266	Family Member	N
270	Endodontist	N
271	General Dentistry Practitioner	N
272	Oral Surgeon	N
273	Orthodontist	N
274	Pediatric Dentist	N
275	Periodontist	N
276	Pedodontist	N
277	Prosthesis	N
280	Independent Lab	N
281	Mobile Lab	N
290	Freestanding X-Ray Clinic	N
291	Mobile X-Ray Clinic	N
300	Free-standing Renal Dialysis Clinic	N
310	Allergist	N
311	Anesthesiologist	N
312	Cardiologist	N
313	Cardiovascular Surgeon	N
314	Dermatologist	N
315	Emergency Medicine Practitioner	N

Table 73.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
316	Family Practitioner	Y
317	Gastroenterologist	N
318	General Practitioner	Y
319	General Surgeon	N
320	Geriatric Practitioner	N
321	Hand Surgeon	N
322	Internist	N
323	Neonatologist	N
324	Nephrologist	N
325	Neurological Surgeon	N
326	Neurologist	N
327	Nuclear Medicine Practitioner	N
328	Obstetrician/Gynecologist	Y
329	Oncologist	N
330	Opthamologist	N
331	Orthopedic Surgeon	N
332	Otologist, Laryngologist, Rhinologist	N
333	Pathologist	N
334	Pediatric Surgeon	N
335	Pediatrician	N
336	Physical Medicine and Rehabilitation Practitioner	N
337	Plastic Surgeon	N
338	Proctologist	N
339	Psychiatrist	N
340	Pulmonary Disease Specialist	N
341	Radiologist	N
342	Thoracic Surgeon	N
343	Urologist	N
344	General Internist	Y
345	General Pediatrician	Y
346	Dispensing Physician	N

Table 73.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
350	Aged and Disabled Waiver	N
351	Autism Waiver	N
352	ICF/MR Waiver	N
353	OBRA/DD	N
354	Medically Fragile Children's Waiver	N
355	Non-Billing Case Manager	N
356	Waiver-Traumatic Brain Injury	N

Section 74: Provider Specialty (Descriptions Order)

T_PR_SPEC_CDE Table

PURPOSE

Lists all provider specialties in specialty description order.

Table 74.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
010	Acute Care	N
350	Aged and Disabled Waiver	N
261	Air Ambulance	N
310	Allergist	N
260	Ambulance	N
020	Ambulatory Surgical Center (ASC)	N
311	Anesthesiologist	N
101	Anesthesiology Assistant	N
200	Audiologist	N
351	Autism Waiver	N
262	Bus	N
212	CSHCS Care Coordinator	N
312	Cardiologist	N
313	Cardiovascular Surgeon	N
210	Care Coordinator for Pregnant Women	N
115	Certified Clinical Social Worker	N
095	Certified Nurse Midwife	N
113	Certified Psychologist	N
094	Certified Registered Nurse Anesthetist (CRNA)	N
116	Certified Social Worker	N
150	Chiropractor	N
264	Common Carrier (Ambulatory)	N

Table 74.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
265	Common Carrier (Non-ambulatory)	N
111	Community Mental Health Center (CMHC)	N
073	Competitive Medical Plans (CMP)	N
130	County Health Department	N
250	DME/Medical Supply Dealer	N
086	Dental Clinic	N
314	Dermatologist	N
346	Dispensing Physician	N
315	Emergency Medicine Practitioner	N
270	Endodontist	N
266	Family Member	N
092	Family Nurse Practitioner	N
083	Family Planning Clinic	N
316	Family Practitioner	Y
080	Federally Qualified Health Clinic (FQHC)	Y
300	Free-standing Renal Dialysis Clinic	N
290	Freestanding X-Ray Clinic	N
317	Gastroenterologist	N
271	General Dentistry Practitioner	N
344	General Internist	Y
345	General Pediatrician	Y
318	General Practitioner	Y
319	General Surgeon	N
320	Geriatric Practitioner	N
211	HIV Case Manager	N
321	Hand Surgeon	N
114	Health Service Provider in Psychology (HSPP)	N
220	Hearing Aid Dealer	N
050	Home Health Agency	N
060	Hospice	N

Table 74.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
031	ICF/MR	N
352	ICF/MR Waiver	N
280	Independent Lab	N
322	Internist	N
161	Licensed Practical Nurse (LPN)	N
071	Managed Care Organization (MCO)	N
082	Medical Clinic	Y
354	Medically Fragile Children's Waiver	N
281	Mobile Lab	N
291	Mobile X-Ray Clinic	N
323	Neonatologist	N
324	Nephrologist	N
325	Neurological Surgeon	N
326	Neurologist	N
355	Non-Billing Case Manager	N
327	Nuclear Medicine Practitioner	N
093	Nurse Practitioner (Other)	N
084	Nurse Practitioner Clinic	N
030	Nursing Facility	N
353	OBRA/DD	N
091	Obstetric Nurse Practitioner	N
328	Obstetrician/Gynecologist	Y
171	Occupational Therapist	N
329	Oncologist	N
330	Opthamologist	N
190	Optician	N
180	Optometrist	N
272	Oral Surgeon	N
273	Orthodontist	N
331	Orthopedic Surgeon	N
332	Otologist, Laryngologist, Rhinologist	N
110	Outpatient Mental Health Clinic	N

Table 74.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
333	Pathologist	N
274	Pediatric Dentist	N
090	Pediatric Nurse Practitioner	N
032	Pediatric Nursing Facility	N
334	Pediatric Surgeon	N
335	Pediatrician	N
276	Pedodontist	N
275	Periodontist	N
240	Pharmacist	N
336	Physical Medicine and Rehabilitation Practitioner	N
170	Physical Therapist	N
100	Physician Assistant	N
337	Plastic Surgeon	N
140	Podiatrist	N
072	Prepaid Health Plan (PHP)	N
338	Proctologist	N
277	Prosthesis	N
011	Psychiatric	N
117	Psychiatric Nurse	N
339	Psychiatrist	N
112	Psychologist	N
340	Pulmonary Disease Specialist	N
341	Radiologist	N
230	Registered Dietitian	N
160	Registered Nurse (RN)	N
162	Registered Nurse Clinical (RNC)	N
012	Rehabilitation	N
040	Rehabilitation Facility	N
033	Residential Care Facility	N
172	Respiratory Therapist	N
070	Risk Based Managed Care (RBMC)	N

Table 74.1 – T_PR_SPEC_CDE

Provider Specialty	Description	Eligible for PMP status in Managed Care
081	Rural Health Clinic (RHC)	N
120	School Corporation	N
173	Speech/Hearing Therapist	N
263	Taxi	N
087	Therapy Clinic	N
342	Thoracic Surgeon	N
085	Title V Clinic	Y
343	Urologist	N
356	Waiver-Traumatic Brain Injury	N

Section 75: Provider Specialty – Subspecialty Xref

T_PR_SPEC_SUBSPEC Table

PURPOSE

Lists the valid subspecialties for each provider specialty.

Table 75.1 – T_PR_SPEC_SUBSPEC

Provider Specialty	Provider Subspecialty
322	023
322	024
335	001
335	002
335	003
335	004
335	005
335	006
335	007
335	008
335	009
335	010
335	011
335	012
335	013
335	014
335	015
335	016
335	017
335	018
335	019
335	020
335	021
335	022

Section 76: Provider Title

T_PR_TITLE_CODE Table

PURPOSE

Lists the title indicated by the first two digits of the provider's license.

Table 76.1 – T_PR_TITLE_CODE

License Prefix	Code	Description
00		No Title
01	MD	Physician
02	DO	Osteopathic Physician
03	DO	Osteopath
04	DRUGLESS	Drugless Chiropractor
05	PT	Physical Therapist
06	PTA	Physical Therapist's Assistant
07	DPM	Podiatrist
08	DC	Chiropractor
09	NMW	Nurse Midwife
10	PA	Physician's Assistant
11	TMP	Temporary Medical Permit
12	DDS	Dentists

Section 77: Provider Type

T_PR_TYPE_CDE Table

PURPOSE

Lists the valid provider types in Indiana*AIM*.

Table 77.1 – T_PR_TYPE_CDE

Type	Description	Level of Care	Peer Group	License Required
01	Hospital	N	Y	N
02	Ambulatory Surgical Center (ASC)	N	N	N
03	Extended Care Facility	Y	N	N
04	Rehabilitation Facility	N	N	N
05	Home Health Agency	N	N	N
06	Hospice	N	N	N
07	Capitation Provider	N	N	N
08	Clinic	N	N	N
09	Advance Practice Nurse	N	N	Y
10	Mid-Level Practitioner	N	N	Y
11	Mental Health Provider	N	N	Y
12	School Corporation	N	N	N
13	Public Health Agency	N	N	N
14	Podiatrist	N	N	Y
15	Chiropractor	N	N	Y
16	Nurse	N	N	Y
17	Therapist	N	N	Y
18	Optometrist	N	N	Y
19	Optician	N	N	N
20	Audiologist	N	N	Y
21	Case Manager (Targeted)	N	N	N
22	Hearing Aid Dealer	N	N	Y
23	Dietitian	N	N	Y
24	Pharmacy	N	N	Y

Table 77.1 – T_PR_TYPE_CDE

Type	Description	Level of Care	Peer Group	License Required
25	DME/Medical Supply Dealer	N	N	N
26	Transportation Provider	N	N	N
27	Dentist	N	N	Y
28	Laboratory	N	N	N
29	X-Ray Clinic	N	N	N
30	End-Stage Renal Disease (RSD) Clinic	N	N	N
31	Physician	N	N	Y
32	Waiver Provider	N	N	N
33	Non-Billing Waiver Case Manager	N	N	N

Section 78: Provider Type Specialty Xref

T_PR_TYPE_SPEC Table

PURPOSE

Cross references provider types to the specialties valid under them.

Table 78.1 –
T_PR_TYPE_SPEC

Type	Specialty
01	10
01	11
01	12
02	20
03	30
03	31
03	32
03	33
04	40
05	50
05	210
05	211
05	212
05	350
05	351
05	352
05	353
05	354
06	60
07	70
07	71
07	72
07	73
08	80
08	81

Table 78.1 –
T_PR_TYPE_SPEC

Type	Specialty
08	82
08	83
08	84
08	85
08	86
08	87
09	90
09	91
09	92
09	93
09	94
09	95
09	210
09	211
09	212
10	100
10	101
11	110
11	111
11	112
11	113
11	114
11	115
11	116
11	117
11	210
11	211
11	212
12	120
13	130
14	140
15	150
16	160

Table 78.1 –
T_PR_TYPE_SPEC

Type	Specialty
16	161
16	162
16	210
16	211
16	212
17	170
17	171
17	172
17	173
18	180
19	190
20	200
21	210
21	211
21	212
22	220
23	210
23	211
23	212
23	230
24	240
24	250
25	250
26	260
26	261
26	262
26	263
26	264
26	265
26	266
27	270
27	271
27	272

Table 78.1 –
T_PR_TYPE_SPEC

Type	Specialty
27	273
27	274
27	275
27	276
27	277
28	280
28	281
29	290
29	291
30	300
31	310
31	311
31	312
31	313
31	314
31	315
31	316
31	317
31	318
31	319
31	320
31	321
31	322
31	323
31	324
31	325
31	326
31	327
31	328
31	329
31	330
31	331
31	332

Table 78.1 –
T_PR_TYPE_SPEC

Type	Specialty
31	333
31	334
31	335
31	336
31	337
31	338
31	339
31	340
31	341
31	342
31	343
31	344
31	345
31	346
32	350
32	351
32	352
32	353
32	354
32	356

Section 79: Public Health Program

T_PUB_HLTH_PGM Table

PURPOSE

Lists the public health programs in Indiana*AIM* to determine which expenditures are to be captured and under what program members are enrolled.

Table 79.1 – T_PUB_HLTH_PGM

Code	Description	Funding
59	590 - Program	59
AR	ARCH	AR
CS	Children With Special Health Care Services (CSHCS)	CS
K2	Hoosier Healthwise Package C	K2
MA	Medicaid	MA
MD	Hoosier Healthwise for People with Disabilities	MA
PC	PCCM	MA
RB	RBMC	MA

Section 80: Questionnaire Recipient Code

T_QUES_REC_CODE Table

PURPOSE

Lists the type of member questionnaire sent by TPL to research suspect TPL policies.

Table 80.1 – T_QUES_REC_CODE

Code	Questionnaire Sent To
A	ABSENT PARENT
C	CARRIER CORR
E	EMPLOYER
H	POLICYHOLDER
L	CARRIER CLAIM
N	COUNTY
O	OTHER
P	PROVIDER
R	RECIPIENT

Section 81: Race

T_CDE_RACE Table

PURPOSE

Lists of valid race codes in Indiana*AIM*.

Table 81.1 – T_CDE_RACE

Code	Description
1	White
2	Black
3	Asian
4	Indian
5	Hispanic
6	Other

Section 82: Recipient Aid Category Specialty Xref

T_AID_CAT_SPEC Table

PURPOSE

Lists the provider specialties a member can select under the managed care program based on aid category.

Table 82.1 – T_AID_CAT_SPEC

Aid Category	Provider Specialty	Auto-Assign Allowed to Specialty
1	316	B
1	318	B
1	344	R
1	345	B
2	316	B
2	318	B
2	328	R
2	344	R
2	345	B
3	316	B
3	318	B
3	328	R
3	344	B
3	345	B
4	316	B
4	318	B
4	328	R
4	344	B
4	345	B
8	316	B
8	318	B
8	328	R
8	344	B
8	345	B

Table 82.1 – T_AID_CAT_SPEC

Aid Category	Provider Specialty	Auto-Assign Allowed to Specialty
9	316	B
9	318	B
9	328	R
9	344	R
9	345	B
C	316	B
C	318	B
C	328	R
C	344	B
C	345	B
E	316	B
E	318	B
E	328	B
F	316	B
F	318	B
F	328	R
F	344	B
F	345	B
H	316	B
H	318	B
H	328	R
H	344	B
H	345	B
M	316	B
M	318	B
M	328	B
N	316	B
N	318	B
N	328	B
O	316	B
O	318	B
O	328	R
O	344	B

Table 82.1 – T_AID_CAT_SPEC

Aid Category	Provider Specialty	Auto-Assign Allowed to Specialty
O	345	B
P	316	B
P	318	B
P	328	B
Q	316	B
Q	318	B
Q	328	R
Q	344	B
Q	345	B
S	316	B
S	318	B
S	328	R
S	344	B
S	345	B
T	316	B
T	318	B
T	328	R
T	344	B
T	345	B
U	316	B
U	318	B
U	328	R
U	344	B
U	345	B
X	316	B
X	318	B
X	345	B
Y	316	B
Y	318	B
Y	345	B
Z	316	B
Z	318	B
Z	345	B

Table 82.1 – T_AID_CAT_SPEC

Aid Category	Provider Specialty	Auto-Assign Allowed to Specialty
10	316	B
10	318	B
10	328	R
10	344	R
10	345	B
1P	316	B
1P	318	B
1P	344	R
1P	345	B
2P	316	B
2P	318	B
2P	344	R
2P	345	B
4P	316	B
4P	318	B
4P	328	R
4P	344	B
4P	345	B
8P	316	B
8P	318	B
8P	328	R
8P	344	B
8P	345	B
CP	316	B
CP	318	B
CP	328	R
CP	344	B
CP	345	B
FP	316	B
FP	318	B
FP	328	R
FP	344	B
FP	345	B

Table 82.1 – T_AID_CAT_SPEC

Aid Category	Provider Specialty	Auto-Assign Allowed to Specialty
HP	316	B
HP	318	B
HP	328	R
HP	344	B
HP	345	B
MP	316	B
MP	318	B
MP	328	B
NP	316	B
NP	318	B
NP	328	B
OP	316	B
OP	318	B
OP	328	R
OP	344	B
OP	345	B
PP	316	B
PP	318	B
PP	328	B
SP	316	B
SP	318	B
SP	328	R
SP	344	B
SP	345	B
TP	316	B
TP	318	B
TP	328	R
TP	344	B
TP	345	B
UP	316	B
UP	318	B
UP	328	R
UP	344	B

Table 82.1 – T_AID_CAT_SPEC

Aid Category	Provider Specialty	Auto-Assign Allowed to Specialty
UP	345	B
XP	316	B
XP	318	B
XP	345	B
YP	316	B
YP	318	B
YP	345	B
ZP	316	B
ZP	318	B
ZP	345	B

Section 83: Recipient Level of Care Code

T_RE_LOC_CODE Table

PURPOSE

Lists the valid level of care codes for a member's segment.

Table 83.1 – T_RE_LOC_CODE

Code	Description	LOC Type Ind
51H	Hospice Program; Authorization for first 90 day period	H
52H	Hospice Program; Authorization for second 90 day period	H
53H	Hospice Program; Authorization for third period; unlimited 60 day segments	H
A	Intermediate Care Level; diverted, Disabled (Under Age 65) - HCBS Waiver Effective 7-1-90	W
B	Intermediate Care Level; Deinstitutionalized, Disabled (Under Age 65) - HCBS Waiver Effective 7-1-90	W
C	Skilled Care Level; Diverted, Disabled (Under Age 65) - HCBS Waiver Effective 7-1-90	W
D	Skilled Care Level; Deinstitutionalized, Disable (Under Age 65) - HCBS Waiver Effective 7-1-90	W
E	Intermediate Care Level; Diverted, Aged (65 and Over) - HCBS Waiver Effective 7-1-90	W
F	Intermediate Care Level; Deinstitutionalized, Aged (65 and Over) - HCBS Waiver Effective 7-1-90	W
G	Skilled Care Level; Diverted, Aged (65 and Over) - HCBS Waiver Effective 7-1-90	W
H	Skilled Care Level;Deinstitutionalized, Aged (65 and Over) - HCBS Waiver Effective 7-1-90	W
I10	General Intermediate Care in AIDS NF; Effective 10-1-98	N
I11	MR/DD specialized intermediate care in NF	N
I13	AIDS Intermediate Care in NF; Effective 10-1-98	N
I20	ICF/MR	N
J	Medically Fragile Children; Diverted - Hospital; Effective 7-1-92	W
K10	TBI Waiver: Diverted-NF LOC (from In-state placement); Effective 1-1-00	W
K11	TBI Waiver: Diverted-ICF/MR LOC (from In-state placement); Eff 1-1-00	W

Table 83.1 – T_RE_LOC_CODE

Code	Description	LOC Type Ind
K12	TBI Waiver: Diverted-Hospital LOC (from In-state placement); Eff 1-1-00	W
L10	TBI Waiver: Deinst-NF LOC (from In-state placement); Eff 1-1-00	W
L11	TBI Waiver: Deinst-ICF/MR LOC (from In-state placement); Eff 1-1-00	W
L12	TBI Waiver: Deinst-Hospital LOC (from In-state placement); Eff 1-1-00	W
L20	TBI Waiver: Deinst-NF LOC (from Out-of-state placement); Eff 1-1-00	W
L21	TBI Waiver: Deinst-ICF/MR LOC (from Out-of-state placement); Eff 1-1-00	W
L22	TBI Waiver: Deinst-Hospital LOC (from Out-of-state placement); Eff 1-1-00	W
N	Nursing Facility Level of Care	N
P	Autistic Waiver, Diverted, Effective 7-1-90	W
Q	Autistic Waiver, Deinsitutionalized, Effective 7-1-90	W
R	Rehabilitation Care; Terminated 10-1-98	N
S10	General Skilled Care in AIDS NF, Effective 10-1-98	N
S11	MR/DD specialized skilled care in NF	N
S12	Vent Skilled Care Unit in NF; Terminated 10-1-98	N
S13	AIDs skilled care unit in NF	N
S14	TBI Skilled Care Unit in NF; Terminated 10-1-98	N
S15	Extensive Skilled Care Unit in NF; Terminated 10-1-98	N
T	DD HCBS Waiver: Diverted; Effective 5-1-92	W
T01	DD HCBS Waiver: Diverted-317 Funding Priority Waiver slot; Eff 7-1-99	W
T02	DD HCBS Waiver: Diverted-317 General Funding (Non-priority slot); Eff 7-1-99	W
U00	DD HCBS Waiver: Deinst From Non-state Facility; Eff 5-1-92	W
U01	DD HCBS Waiver: Deinst From Non-state Facility-317 Funding Priority Waiver slot; Eff 7-1-99	W
U02	DD HCBS Waiver: Deinst From Non-state Facility-317 General Funding (Non-priority slot); Eff 7-1-99	W
U10	DD HCBS Waiver: Conversion Group Home (Small Private)	W
U20	DD HCBS Waiver: Conversion Res-Care (Large Private)	W
U21	DD HCBS Waiver: Conversion SVNH (Large Private)	W

Table 83.1 – T_RE_LOC_CODE

Code	Description	LOC Type Ind
U22	DD HCBS Waiver: Conversion Arcadia (Large Private)	W
U23	DD HCBS Waiver: Conversion Holy Cross Living Center (Large Private)	W
U24	DD HCBS Waiver: Conversion Knox Co. ARC (Large Private)	W
U25	DD HCBS Waiver: Conversion Millers Merry Manor (Large Private)	W
U26	DD HCBS Waiver: Conversion New Horizon Dev Cntr (Large Private)	W
U27	DD HCBS Waiver: Conversion Normal Life of Indiana (Large Private)	W
U28	DD HCBS Waiver: Conversion North Willow Center (Large Private)	W
U29	DD HCBS Waiver: Cascade due to Non-State Facility Conversion	W
U30	DD HCBS Waiver: Conversion Oak Meadows Learning Cntr (Large Private)	W
U31	DD HCBS Waiver: Conversion Procare Developmental Cntr (Large Private)	W
U32	DD HCBS Waiver: Conversion Riverbend Learning Cntr (Large Private)	W
V00	DD HCBS Waiver: Deinst From State Facility; Eff 5-1-92	W
V01	DD HCBS Waiver: Deinst From State Facility-317 Funding Priority Waiver slot; Eff 7-1-99	W
V20	DD HCBS Waiver: Conversion Central State Hospital	W
V21	DD HCBS Waiver: Conversion NCSDC; Effective 7-1-96	W
V22	DD HCBS Waiver: Conversion NISDC; Effective 7-1-96	W
V23	DD HCBS Waiver: Conversion FWSDC; Effective 7-1-96	W
V24	DD HCBS Waiver: Conversion MSDC; Effective 7-1-96	W
V25	DD HCBS Waiver: Conversion Evansville SH/DTU; Eff 7-1-96	W
V26	DD HCBS Waiver: Conversion Madison/Gold; Eff 7-1-96	W
V27	DD HCBS Waiver: Conversion Logansport JEU; Eff 7-1-96	W
V29	DD HCBS Waiver: Cascade due to State Facility Conversion	W
W	DD HCBS Waiver: Deinst From Nursing Facility; Eff 5-1-92	W
W01	DD HCBS Waiver: Deinst From Nursing Facility-317 Funding Priority Waiver slot; Eff 7-1-99	W
X	Medically Fragile Children; Deinstitutionalized - Hospital; Effective 7-1-92	W

Table 83.1 – T_RE_LOC_CODE

Code	Description	LOC Type Ind
Y	Medically Fragile Children; Diverted - Nursing Facility Skilled Care; Effective 7-1-92	W
Z	Medically Fragile Children; Deinstitutionalized - Nursing Facility Skilled Care; Effective 7-1-92	W

Section 84: Refugee

T_REFUGEE Table

PURPOSE

Indicates if a member is a refugee.

Table 84.1 – T_REFUGEE

Code	Refugee
C	CUBAN
I	INDOCHINESE
N	NONE

Section 85: Region

T_REGION Table

PURPOSE

Lists the valid region codes in Indiana*AIM* to which a claim is classified.

Table 85.1 – T_REGION

Region Number	Description
10	PAPER CLAIMS WITH NO ATTACHMENTS
11	PAPER CLAIMS WITH ATTACHMENTS
12	CCF
15	PAPER CLAIMS WITH NO PROVIDER ID
20	ELECTRONIC CLAIMS WITH NO ATTACHMENTS
21	ELECTRONIC CLAIMS WITH ATTACHMENTS
22	SHADOW CLAIMS
25	POINT OF SERVICE CLAIMS
26	POINT OF SERVICE CLAIMS WITH ATTACHMENTS
33	TO BE DEFINED
40	CLAIMS CONVERTED FROM OLD MMIS
41	590 CLAIMS CONVERTED FROM OLD MMIS
45	ADJUSTMENTS CONVERTED FROM OLD MMIS
46	590 ADJUSTMENTS CONVERTED FROM OLD MMIS
47	CONVERTED CREDITS
48	CONVERTED VOIDS
49	RECIPIENT LINKING CLAIMS
50	ADJUSTMENTS - NON-CHECK RELATED
51	ADJUSTMENTS - CHECK RELATED
52	SHADOW CLAIM ADJUSTMENTS
53	SHADOW CLAIM ADJUSTMENTS
54	MASS ADJUSTMENTS - VOID TRANSACTION
55	MASS ADJUSTMENTS - NURSING HOME
56	MASS ADJUSTMENTS – FINANCIAL

Table 85.1 – T_REGION

Region Number	Description
57	MASS ADJUSTMENTS - REPROCESS BY EDS SE
58	ADJUSTMENTS - PROCESSED BY EDS SE
59	POS REVERSAL ADJUSTMENT
60	NON-CLAIM SPECIFIC FINANCIAL TRANSACTIONS
70	HMO CAPITATION / HMO
80	CLAIMS REPROCESSED BY EDS SYSTEMS ENGINEERS
90	SPECIAL PROJECTS
99	CONVERTED CLAIM WITH DUPLICATE ICN

Section 86: Reissue Check Reason

T_CHK_REISSUE_RSN Table

PURPOSE

Lists the reasons a payment check would be reissued.

Table 86.1 – T_CHK_REISSUE_RSN

Code	Description
A	CHECK OUTSTANDING
C	CHECK VOIDED
D	STOP/CHECK PRESENT
E	STOP/CHECK NOT PRESENTED
F	MUTILATED CHECK
G	VOID/INCORRECT PAYMENT
H	VOID/WRONG PROVIDER
I	VOID/DUPLICATE PAYMENT
J	VOID/WRONG LOCATION
K	VOID/WRONG PROVIDER ID
L	VOID/CHECK STALE-DATED
M	VOID/NEW TAX ID NUMBER
N	VOID/WRONG PROCEDURE CODE
O	VOID/FAILED EFT

Section 87: Relationship Code

T_RELATION_CODE Table

PURPOSE

Used in TPL system to denote the member's relationship to the policyholder.

Table 87.1 – T_RELATION_CODE

Code	Description
A	FATHER
B	MOTHER
C	SPOUSE
D	EX-SPOUSE
E	STEPPARENT
F	GRANDPARENT
G	SELF
S	SIBLING
Z	OTHER

Section 88: Revenue Code

T_REVENUE_CODE

PURPOSE:

Lists the valid revenue codes in Indiana*AIM*.

> *Revenue codes can be viewed through the online windows by clicking on the Reference button from the Main Menu, then by clicking the Revenue button.*

Section 89: Revenue Type

T_REV_TYPE Table

PURPOSE

Lists the types of revenue codes used by the Reference subsystem. These groupings of the same type revenue codes are used in editing and pricing to streamline claims processing.

Table 89.1 – T_REV_TYPE

Code	Description
1	Emergency Room
2	Surgery
3	Treatment Room
4	Stand Alone
5	Osteopath
6	Professional Fee
7	Transportation
8	Inpatient
9	Take Home Drugs
10	Recovery Room
11	Laboratory
12	Radiology
13	Add On
14	Emergency Needed
15	Inc in Treat Room
16	Ancillary
17	Accommodation
18	Coronary Care
19	Non Coronary Care
20	Blood
21	Inpatient Ancillary
22	Inpatient Accommodation
23	Hospital Leave
24	Nurse Hm Ancillary Subset

Table 89.1 – T_REV_TYPE

Code	Description
25	Old Home Health Ancillary
26	SNF/ICF Mental Hlth Aged
27	Mental Health
28	HBO Therapy
29	Medicare B Covered
30	Medicare A Covered
31	Old Home Health Accom
32	Semi Private Accomodation
33	Private Room Accomodation
34	LTC Therapeutic Leave
35	LTC Hospital Leave
36	PAS Inpatient
37	No HCPC Code required
38	Room/Board 3 And 4 Bed
39	No Electronic Billing TPL
40	1 bed psych
41	2 bed psych
42	3/4 bed psych
43	Hospice Rev Codes
44	Hospice - Routine Care
45	Hospice - Continuous Care
46	Hospice - Inpatient Care
47	Hospice - General Inpatient
48	Hospice - Nursing Home
49	Hospice - Physician
50	Hospice - Leave Days
51	Hospice Rev Codes - Multiple units
52	Hospice - Nursing Home - QMB
53	Hospital Leave Days
54	Therapeutic Leave Days
55	Non-covered Psych Leave Days
56	Renal Dialysis Multiple Units

Section 90: State

T_STATE Table

PURPOSE

Lists the valid state codes in Indiana*AIM*.

Table 90.1 – T_STATE

Code	State
AB	Alberta
AK	Alaska
AL	Alabama
AR	Arkansas
AZ	Arizona
BC	British Columb.
CA	California
CO	Colorado
CT	Connecticut
DC	Distr of Columb
DE	Delaware
FL	Florida
GA	Georgia
HI	Hawaii
IA	Iowa
ID	Idaho
IL	Illinois
IN	Indiana
KS	Kansas
KY	Kentucky
LA	Louisiana
MA	Massachusetts
MB	Manitoba
MD	Maryland
ME	Maine
MI	Michigan

Table 90.1 – T_STATE

Code	State
MN	Minnesota
MO	Missouri
MS	Mississippi
MT	Montana
NB	New Brunswick
NC	North Carolina
ND	North Dakota
NE	Nebraska
NF	Newfoundland
NH	New Hampshire
NJ	New Jersey
NM	New Mexico
NS	Nova Scotia
NT	Northwest Terr.
NV	Nevada
NY	New York
OH	Ohio
OK	Oklahoma
ON	Ontario
OR	Oregon
PA	Pennsylvania
PE	Prince Edwrd Is
PQ	Quebec
PR	Puerto Rico
RI	Rhode Island
SC	South Carolina
SD	South Dakota
SK	Saskatchewan
TN	Tennessee
TX	Texas
UT	Utah
VA	Virginia
VT	Vermont

Table 90.1 – T_STATE

Code	State
WA	Washington
WI	Wisconsin
WV	West Virginia
WY	Wyoming
YT	Yukon Territory

Section 91: State Region

T_STATE_REGION Table

PURPOSE

Lists the valid state regions in Managed Care.

Table 91.1 – T_STATE_REGION

Code	Description
C	Central
N	Northern
S	Southern

Section 92: Stop Reason

T_RE_ELIG_STOP Table

PURPOSE

Lists the stop reasons for a member's eligibility segment.

Table 92.1 – T_RE_ELIG_STOP

Code	Description
E	Regular
G	Death
O	Open

Section 93: Suspect Code

T_SUSPECT_CODE Table

PURPOSE

Indicates if a TPL policy is valid or being researched as suspect in Indiana*AIM*.

Table 93.1 – T_SUSPECT_CODE

Code	Description
1	VALID
2	SYSTEM
3	MANUAL

Section 94: Tooth

T_TOOTH Table

PURPOSE

Indicates the valid tooth codes to be billed on dental claims.

Table 94.1 – T_TOOTH

Code	Description
1	UPPER RIGHT THIRD MOLAR
10	UPPER LEFT LATERAL INCISOR
11	UPPER LEFT CANINE (CUSPID)
12	UPPER LEFT FIRST PREMOLAR-1ST BICUSPID
13	UPPER LEFT SECOND PREMOLAR-2ND BICUSPID
14	UPPER LEFT FIRST MOLAR
15	UPPER LEFT SECOND MOLAR
16	UPPER LEFT THIRD MOLAR
17	LOWER LEFT THIRD MOLAR - WISDOM TOOTH
18	LOWER LEFT SECOND MOLAR
19	LOWER LEFT FIRST MOLAR
2	UPPER RIGHT SECOND MOLAR
20	LOWER LEFT SECOND PREMOLAR-2ND BICUSPID
21	LOWER LEFT FIRST PREMOLAR-1ST BICUSPID
22	LOWER LEFT CANINE - CUSPID
23	LOWER LEFT LATERAL INCISOR
24	LOWER LEFT CENTRAL INCISOR
25	LOWER RIGHT CENTRAL INCISOR
26	LOWER RIGHT LATERAL INCISOR
27	LOWER RIGHT CANINE - CUSPID
28	LOWER RIGHT FIRST PREMOLAR-1ST BICUSPID
29	LOWER RIGHT SECOND PREMOLAR-2ND BICUSPID
3	UPPER RIGHT FIRST MOLAR
30	LOWER RIGHT FIRST MOLAR
31	LOWER RIGHT SECOND MOLAR
32	LOWER RIGHT THIRD MOLAR - WISDOM TOOTH

Table 94.1 – T_TOOTH

Code	Description
4	UPPER RIGHT SECOND PREMOLAR-2ND BICUSPID
5	UPPER RIGHT FIRST PREMOLAR-1ST BICUSPID
6	UPPER RIGHT CANINE - CUSPID
7	UPPER RIGHT LATERAL INCISOR
8	UPPER RIGHT CENTRAL INCISOR
9	UPPER LEFT CENTRAL INCISOR
A	UPPER RIGHT SECOND PRIMARY MOLAR
B	UPPER RIGHT FIRST PRIMARY MOLAR
C	UPPER RIGHT PRIMARY CANINE - CUSPID
D	UPPER RIGHT LATERAL INCISOR
E	UPPER RIGHT CENTRAL INCISOR
F	UPPER LEFT CENTRAL INCISOR
G	UPPER LEFT LATERAL INCISOR
H	UPPER LEFT PRIMARY CANINE - CUSPID
I	UPPER LEFT FIRST PRIMARY MOLAR
J	UPPER LEFT SECOND PRIMARY MOLAR
K	LOWER LEFT SECOND PRIMARY MOLAR
L	LOWER LEFT FIRST PRIMARY MOLAR
M	LOWER LEFT PRIMARY CANINE - CUSPID
N	LOWER LEFT LATERAL INCISOR
O	LOWER LEFT CENTRAL INCISOR
P	LOWER RIGHT CENTRAL INCISOR
Q	LOWER RIGHT LATERAL INCISOR
R	LOWER RIGHT PRIMARY CANINE - CUSPID
S	LOWER RIGHT FIRST PRIMARY MOLAR
T	LOWER RIGHT SECOND PRIMARY MOLAR

Section 95: Tooth Surface

T_TOOTH_SURFACE Table

PURPOSE

Indicates the valid tooth surfaces to bill on dental claims.

Table 95.1 – T_TOOTH_SURFACE

Code	Description
B	BUCCAL
D	DISTAL
F	FACIAL
I	INCISAL
L	LINGUAL
M	MESIAL
O	OCCLUSAL

Section 96: TPL AR Reasons

T_TPL_AR_REASONS Table

PURPOSE

Indicates the reasons an A/R was updated for TPL rebill.

Table 96.1 – T_TPL_AR_REASONS

Code	Description
10	CLAIM PAID IN FULL
11	PAID TO POLICY LIMIT
12	OVERPAID
13	ADDITIONAL FUNDS RECEIVED
18	MONEY REFUNDED TO CARRIER
20	DEFAULT POSTING AT RID
21	DEFAULT POSTING AT RID W/FDOS
22	DEFAULT POSTING AT CARRIER
23	DEFAULT POSTING AT CARRIER W/FDOS
24	CLAIM HAS BEEN ADJUSTED – ADJUSTMENT BILL
25	CLAIM HAS BEEN EXCLUDED FROM REBILLING
26	CLAIM SYSTEMATICALLY CLOSED – NO ANSWER TO BILLING
50	NO REASON IDENTIFIED
51	POLICY TERMINATED
52	SERVICE BENEFITS EXHAUSTED
53	ANNUAL SERVICE BENEFITS EXHAUSTED
54	PRE-EXISTING CONDITION
55	INVALID/MISSING DATA – CARRIER
56	DEDUCTIBLE ETC. NOT MET
57	BENEFITS PAID BY OTHER POLICY
58	PROVIDER PREVIOUSLY PAID
59	OTHER ENTITY PAID
60	DX OR PROCEDURE NOT COVERED
61	RX NOT COVERED UNDER THIS PLAN
62	RX CARD ONLY - NO REIMBURSEMENT

Table 96.1 – T_TPL_AR_REASONS

Code	Description
63	DUPLICATE CHARGES PREVIOUSLY CONSIDERED
64	RECIPIENT NOT COVERED UNDER THIS POLICY
65	CHARGES INCURRED PRIOR TO COVERAGE EFFECTIVE DATE
66	PAST FILING LIMIT
67	PROVIDER IS OUT OF THE PLAN
68	MEDICARE EOMB REQUESTED
69	PRIOR AUTHORIZATION REQUIRED FOR SERV
70	NEIC REJECTION
71	PROVIDER (NAME, ADDRESS & CREDENTIALS)
72	MEDICAL RECORDS (TIME, DATES, ETC.)
73	ITEMIZED BILL
74	RESUBMIT TO ANOTHER CARRIER
75	NO PAYMENT DUE TO NO PATIENT LIABILITY
76	ACCIDENT REPORT NEEDED
77	TIMELY FILING LIMIT REACTED
78	PENDING
79	HMS DENIED WITHOUT SUPPLYING A REASON
98	DUMMY AR CREATE INCORRECTLY
99	REVERSED DUPLICATES

Section 97: TPL Restricted Reason Code

T_TPL_REST_RSN_CDE Table

PURPOSE

Indicates the reason a TPL policy was restricted.

Table 97.1 – T_TPL_REST_RSN_CDE

Code	Reason
1	STATE DIRECTION
2	LIFETIME BENEFITS EXHAUSTED
3	ANNUAL BENEFITS EXHAUSTED
4	PRE-EXISTING CONDITION
5	SERVICES NOT A BENEFIT OF PLCY
6	CARRIER WILL NOT PAY PRV/MDCAD

Section 98: Type of Bill

T_TYPE_OF_BILL Table

PURPOSE

Indicates the valid types of bill to be billed on a UB-92.

Table 98.1 – T_TYPE_OF_BILL

Code	Description
110	HOSPITAL INPATIENT
111	HOSPITAL INPATIENT
115	HOSPITAL INPATIENT
130	HOSPITAL OUTPATIENT
131	HOSPITAL OUTPATIENT
135	HOSPITAL OUTPATIENT
140	HOSPITAL OTH DX SVCS
141	HOSPITAL OTH DX SVCS
145	HOSPITAL OTH DX SVCS
181	HOSPITAL SWING BEDS
185	HOSPITAL SWING BEDS
210	SKILLED NURSING
211	SKILLED NURSING
215	SKILLED NURSING
221	SNF INPT PART B ONLY
222	SNF INPT PART B ONLY
223	SNF INPT PART B ONLY
224	SNF INPT PART B ONLY
225	SNF INPT PART B ONLY
231	SNF OUTPATIENT
235	SNF OUTPATIENT
330	HOME HEALTH
331	HOME HEALTH
335	HOME HEALTH
650	INTERMED CARE FACIL
651	INTERMED CARE FACIL

Table 98.1 – T_TYPE_OF_BILL

Code	Description
655	INTERMED CARE FACIL
660	ICF/MR
661	ICF/MR
665	ICF/MR
670	CRF/DD
671	CRF/DD
675	CRF/DD
720	HOSPITAL DIALYSS CTR
721	HOSPITAL DIALYSS CTR
725	HOSPITAL DIALYSS CTR
730	FREE STANDING CLINIC
731	FREE STANDING CLINIC
735	FREE STANDING CLINIC
740	OUTPT REHAB FACILITY
741	OUTPT REHAB FACILITY
745	OUTPT REHAB FACILITY
750	COMP OUTPT REHAB FAC
751	COMP OUTPT REHAB FAC
755	COMP OUTPT REHAB FAC
822	HOSPICE
830	AMBULATORY SURG CTR
831	AMBULATORY SURG CTR
835	AMBULATORY SURG CTR

Section 99: Type of Bill Claim Type Xref

T_TOB_CT_XREF Table

PURPOSE

Cross-references the types of bill to the claims types on which they are valid.

Table 99.1 – T_TOB_CT_XREF

TOB	Claim Type
111	A
115	A
181	A
185	A
211	A
215	A
221	A
222	A
223	A
224	A
225	A
231	A
235	A
651	A
655	A
661	A
665	A
671	A
675	A
131	C
135	C
141	C
145	C
181	C
185	C

Table 99.1 – T_TOB_CT_XREF

TOB	Claim Type
221	C
222	C
223	C
224	C
225	C
231	C
235	C
331	C
335	C
721	C
725	C
731	C
735	C
741	C
745	C
751	C
755	C
831	C
835	C
330	H
331	H
335	H
336	H
337	H
338	H
340	H
341	H
345	H
346	H
347	H
348	H
822	H
110	I

Table 99.1 – T_TOB_CT_XREF

TOB	Claim Type
111	I
112	I
113	I
114	I
115	I
116	I
117	I
118	I
210	L
211	L
215	L
216	L
217	L
218	L
650	L
651	L
655	L
656	L
657	L
658	L
660	L
661	L
665	L
666	L
667	L
668	L
670	L
671	L
675	L
676	L
677	L
678	L
130	O

Table 99.1 – T_TOB_CT_XREF

TOB	Claim Type
131	O
135	O
136	O
137	O
138	O
140	O
141	O
145	O
146	O
147	O
148	O
720	O
721	O
725	O
726	O
727	O
728	O
740	O
741	O
745	O
746	O
747	O
748	O
750	O
751	O
755	O
756	O
757	O
758	O
810	O
811	O
815	O
816	O

Table 99.1 – T_TOB_CT_XREF

TOB	Claim Type
817	O
818	O
820	O
821	O
823	O
824	O
825	O
826	O
827	O
828	O
830	O
831	O
835	O
836	O
837	O
838	O

Section 100: Type of Bill Procedure Xref

T_TOB_PROC_XREF Table

PURPOSE

Cross-references the types of bill to the procedure codes for which they are valid.

Table 100.1 – T_TOB_PROC_XREF

TOB	Procedure Code
141	2581
141	2582
141	2583
141	6413
145	2581
145	2582
145	2583
145	6413

Section 101: Valid HIB Suffix

T_RE_VALID_HIB Table

PURPOSE

Indicates the valid prefixes for a Medicare HIB.

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
A	Wage Earner	1
B	Wife age 62 or older	1
B1	Husband age 62 or older	1
B2	Wife under age 62	1
B3	Wife age 62 or older	2
B4	Husband age 62 or older	2
B5	Wife under age 62	2
B6	Divorced Wife	1
B7	Wife age 62 or older	3
B8	Wife under age 62	3
B9	Divorced Wife	2
BA	Wife age 62 or older	4
BD	Wife age 62 or older	5
BG	Husband age 62 or older	3
BH	Husband age 62 or older	4
BJ	Husband age 62 or older	5
BK	Wife age 62 or older	4
BL	Wife under age 62	5
BN	Divorced Wife	3
BP	Divorced Wife	4
BQ	Divorced Wife	5
BR	Divorced Husband	1
BT	Divorced Husband	1
BW	Young Husband	2
BY	Young Husband	1
C1	Child (including disabled/student child)	1

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
C2	Child (including disabled/student child)	2
C3	Child (including disabled/student child)	3
C4	Child (including disabled/student child)	4
C5	Child (including disabled/student child)	5
C6	Child (including disabled/student child)	6
C7	Child (including disabled/student child)	7
C8	Child (including disabled/student child)	8
C9	Child (including disabled/student child)	9
CA	Child (including disabled/student child)	10
CB	Child (including disabled/student child)	11
CC	Child (including disabled/student child)	12
CD	Child (including disabled/student child)	13
CE	Child (including disabled/student child)	14
CF	Child (including disabled/student child)	15
CG	Child (including disabled/student child)	16
CH	Child (including disabled/student child)	17
CI	Child (including disabled/student child)	18
CJ	Child (including disabled/student child)	19
CK	Child (including disabled/student child)	20
D	Widow age 60 or older	1
D1	Widower age 60 or older	1
D2	Widow age 60 or older	2
D3	Widower age 60 or older	2
D4	Widow remarried after age 60	1
D5	Widower remarried	1
D6	Surviving divorced wife	1
D7	Surviving divorced wife	2
D8	Widow age 60 or older	3
D9	Widow remarried after age 60	2
DA	Widow remarried after age 60	3
DC	Surviving divorced husband	1
DD	Widow age 60 or older	4
DG	Widow age 60 or older	5

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
DH	Widower are 60 or older	3
DJ	Widower age 60 or older	4
DL	Widow remarried after age 60	4
DM	Surviving divorced husband	2
DN	Widow remarried after age 60	5
DP	Widower remarried	2
DQ	Widower remarried	3
DR	Widower remarried	4
DS	Surviving divorced husband	3
DT	Widower remarried	5
DV	Surviving divorced wife	3
DW	Surviving divorced wife	4
DX	Surviving divorced husband	4
DY	Surviving divorced wife	5
DZ	Surviving divorced husband	5
E	Mother	1
E1	Surviving divorced mother	1
E2	Mother	2
E3	Surviving divorced mother	2
E4	Widowed father	1
E5	Surviving divorced father	1
E6	Widowed father	2
E7	Mother	3
E8	Mother	4
E9	Surviving divorced father	2
EA	Mother	5
EB	Surviving divorced mother	3
EC	Surviving divorced mother	4
ED	Surviving divorced mother	5
EF	Widowed father	3
EG	Widowed father	4
EJ	Surviving divorced father	3
EK	Surviving divorced father	4

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
EM	Surviving divorced father	5
F1	Father	1
F2	Mother	1
F3	Stepfather	1
F4	Stepmother	1
F5	Adopting father	1
F6	Adopting mother	1
F7	Father	2
F8	Mother	2
G1		
G2		
G3		
G4		
G7		
G8		
G9		
H		
H4		
HA		
HB		
HB1		
HB2		
HB3		
HB5		
HB6		
HB7		
HB8		
HBB		
HBY		
HC1		
HC2		
J		
J1	Entitled to HIB - less than 3 quarters	1

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
J2	Entitled to HIB - 3 quarters or more	1
J3	Not entitled to HIB-less than 3 quarters	1
J4	Not entitled to HIB - 3 quarters or more	1
JA		
K		
K1	Wife entitled to HIB - less than 3 QCs	1
K2	Wife entitled to HIB - 3 QCs or more	1
K3	Wife not entitled to HIB-less than 3 QCs	1
K4	Wife not entitled to HIB-3 QCs or more	1
K5	Wife entitled to HIB - less than 3 QCs	2
K6	Wife entitled to HIB - 3 QCs or more	2
K7	Wife not entitled to HIB-less than 3 QCs	2
K8	Wife not entitled to HIB-3 QCs or more	2
K9	Wife entitled to HIB - less than 3 QCs	3
KA	Wife entitled to HIB - 3 QCs or more	3
KB	Wife not entitled to HIB-less than 3 QCs	3
KC	Wife not entitled to HIB-3 QCs or more	3
KD	Wife entitled to HIB - less than 3 QCs	4
KE	Wife entitled to HIB - 3 QCs or more	4
KF	Wife not entitled to HIB-less than 3 QCs	4
KG	Wife not entitled to HIB-3 QCs or more	4
KH	Wife entitled to HIB - less than 3 QCs	5
KJ	Wife entitled to HIB - 3 QCs or more	5
KL	Wife not entitled to HIB-less than 3 QCs	5
KM	Wife not entitled to HIB-3 QCs or more	5
L1		
L2		
L3		
L4		
L5		
L6		
L7		
L8		

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
L9		
LM	Black Lung Minor	1
LS		
LS5		
LT		
LW	Black Ling miner's widow	1
LX		
M	Uninsured (not ent to HIB, qual for SMIB	1
M1	Insured (qual for HIB but requested SMIB	1
MA		
MH		
P1		
P2		
P3		
P4		
P5		
P6		
PA		
PD		
PH		
S1		
S2		
S3		
S4		
S5		
S6		
S7		
S8		
T	Uninsured (ent to HIB under insured prov	1
T2		
T3		
T4		
T5		

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
T6		
T7		
T8		
T9		
TA		
TB		
TB1		
TB2		
TB6		
TBR		
TBY		
TC		
TC1		
TC2		
TC3		
TC4		
TC5		
TC6		
TC7		
TC8		
TC9		
TD		
TD1		
TD6		
TDC		
TE		
TE1		
TE4		
TE5		
TF		
TF1		
TF3		
TF5		

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
TF7		
TG		
TG3		
TG4		
TG5		
TG9		
TGT		
TGW		
TH		
TH7		
TH8		
THG		
THN		
TJ		
TJA		
TJH		
TJK		
TJP		
TK		
TKD		
TKJ		
TKL		
TKQ		
TL		
TL2		
TL3		
TL7		
TL9		
TLM		
TLP		
TM		
TMA		
TMH		

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
TMQ		
TMS		
TMV		
TN		
TND		
TNJ		
TNL		
TNR		
TNW		
TNX		
TP		
TPG		
TPK		
TPN		
TPT		
TPY		
TPZ		
TQ		
TQ2		
TQ3		
TQ4		
TQ6		
TQ8		
TR		
TR2		
TR3		
TR6		
TR9		
TS		
TS7		
TSB		
TSF		
TSJ		

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
TT		
TT8		
TTC		
TTG		
TTK		
TU		
TUA		
TUD		
TUF		
TUG		
TUH		
TUJ		
TUM		
TV		
TVF		
TVG		
TVJ		
TW		
TW1		
TW6		
TWR		
TX		
TX2		
TX3		
TX7		
TXT		
TY		
TY4		
TY5		
TY8		
TZ		
TZ9		
TZB		

Table 101.1 – T_RE_VALID_HIB

Code	Description	Num_claimant
TZC		
W	Disabled widow	1
W1	Disabled widower	1
W2	Disabled widow	2
W3	Disabled widower	2
W4	Disabled widow	3
W5	Disabled widower	3
W6	Disabled surviving divorced wife	1
W7	Disabled surviving divorced wife	2
W8	Disabled surviving divorved wife	3
W9	Disabled widow	4
WA		
WB	Disabled widower	4
WC	Disabled surviving divorced wife	4
WCA		
WCD		
WD		
WDH		
WF	Disabled widow	5
WG	Disabled widower	5
WH		
WJ	Disabled surviving divorced wife	5
WR	Disabled surviving divorced husband	1
WT	Disabled surviving divorced husband	2

Section 102: Error Status Code – EOB Cross Reference

T_ERROR_DISP and T_EOB Tables

PURPOSE

Cross-references the error status codes (ESC) to the explanation of benefit (EOB) codes valid for each ESC.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
201	BILLING PROVIDER I.D. NUMBER MISSING	201	BILLING PROVIDER'S NUMBER IS MISSING-PLEASE PROVIDE AND RESUBMIT.
202	BILLING PROVIDER I.D. IN INVALID FORMAT	202	PROVIDER NUMBER IS NOT IN A VALID FORMAT. THE CORRECT FORMAT IS NINE NUMERIC C
203	RECIPIENT I.D. NUMBER MISSING	203	RECIPIENT I.D. NUMBER IS MISSING-PLEASE PROVIDE AND RESUBMIT.
204	RECIPIENT I.D. NUMBER NOT IN VALID FORMAT	204	RECIPIENT I.D. NUMBER IS NOT A VALID FORMAT-PLEASE CHECK RECIPIENT'S I.D. CARD
205	PRESCRIBING PRACTITIONER'S LICENSE NO. MISSING	205	THE PRESCRIBING PRACTICIONER'S LICENSE NUMBER IS MISSING-PLEASE PROVIDE AND RES
206	PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT	206	THE PRESCRIBING PRACTITIONER'S LICENSE NUMBER SUBMITTED ON THIS CLAIM IS NOT IN
207	EMERGENCY INDICATOR INVALID	207	INVALID EMERGENCY INDICATOR CODE-IF THIS WAS AN EMERGENCY, IT SHOULD BE "Y" FOR
208	PREGNANCY INDICATOR INVALID	208	INVALID PREGNANCY INDICATOR CODE-IT SHOULD BE "P" IF THE PATIENT IS PREGNANT AN

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
209	NURSING FACILITY PATIENT INDICATOR INVALID	209	NURSING FACILITY INDICATOR INVALID-IF THE PATIENT IS IN A NURSING FACILITY, IT
210	BRAND MEDICALLY NECESSARY INDICATOR INVALID	210	BRAND MEDICALLY NECESSARY INDICATOR INVALID-THE VALID VALUES ARE "0", "5", OR "
211	REFILL INDICATOR INVALID	211	REFILL INDICATOR IS INVALID-THE VALID VALUES ARE 2 DIGIT NUMBERS FROM "00" TO "
212	RX NUMBER IS MISSING	212	PRESCRIPTION NUMBER IS MISSING-THE PRESCRIPTION NUMBER CAN BE UP TO TEN ALPHA A
213	DATE PRESCRIBED IS MISSING	213	DATE PRESCRIBED IS MISSING. THE PROPER FORMAT IS MMDDYY -EXAMPLE, 011295. PLE
214	DATE PRESCRIBED IS INVALID	214	DATE PRESCRIBED IS NOT IN A VALID FORMAT. THE PROPER FORMAT IS MMDDYY-EXAMPLE,
215	DATE DISPENSED IS MISSING	215	DATE DISPENSED IS MISSING. THE PROPER FORMAT IS MMDDYY-EXAMPLE, 011295. PLEAS
216	DATE DISPENSED IS INVALID	216	DATE DISPENSED IS NOT IN A VALID FORMAT. THE PROPER FORMAT IS MMDDYY-EXAMPLE,
217	NDC MISSING	217	NDC NUMBER IS MISSING-AN NDC NUMBER CAN BE UP TO ELEVEN NUMERIC CHARACTERS. FO
218	NDC INVALID FORMAT	218	NDC NUMBER IS NOT IN A VALID FORMAT-AN NDC NUMBER CAN BE UP TO ELEVEN NUMERIC
219	QUANTITY DISPENSED IS MISSING	219	THE QUANTITY DISPENSED INFORMATION IS MISSING. IT SHOULD INDICATE THE QUANTITY
220	QUANTITY DISPENSED IS INVALID	220	THE QUANTITY DISPENSED INFORMATION IS INVALID. IT SHOULD INDICATE THE QUANTITY

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
221	DAYS SUPPLY MISSING	221	THE ESTIMATED DAYS SUPPLY INFORMATION IS MISSING-IT CAN BE UP TO 999 DAYS. PLE
222	ESTIMATED DAYS SUPPLY INVALID	222	THE ESTIMATED DAYS SUPPLY IS NOT VALID-IT SHOULD BE A NUMERIC CHARACTER FROM 1
223	RESERVE FOR FUTURE USE	223	THE DIAGNOSIS TREATED INDICATOR IS MISSING-THE CODES MUST REFERENCE AT LEAST ON
224	DIAGNOSIS TREATED INDICATOR INVALID	224	THE DIAGNOSIS TREATED INDICATOR IS NOT IN THE CORRECT FORMAT-THE NUMBER(S) MUST
225	RESERVED FOR FUTURE USE	225	THE ESTIMATED DAYS SUPPLY IS NOT VALID-IT SHOULD BE A NUMBER BETWEEN 0 AND 999.
226	REFERRING PHYSICIAN NUMBER IS MISSING	226	THIS CLAIM REQUIRES A VALID REFERRING PHYSICAN NUMBER. PLEASE CONSULT REFERRIN
227	THIRD PARTY PAYMENT AMOUNT INVALID	227	THE THIRD PARTY PAYMENT AMOUNT IS INVALID-IF A THIRD PARTY INSURANCE CARRIER WA
228	PROVIDER SIGNATURE MISSING	228	YOUR CLAIM WAS RECEIVED WITHOUT A VALID SIGNATURE. THE SIGNATURE MUST BE AN AC
229	RESERVED FOR FUTURE USE	229	INVALID PREGNANCY INDICATOR CODE-IT SHOULD BE "P" IS THE PATIENT IS PREGNANT AN
230	RESERVED FOR FUTURE USE	230	INVALID EMERGENCY INDICATOR CODE-IF IT WAS AN EMERGENCY IT SHOULD BE "Y" FOR YE
231	RENDERING PROVIDER NUMBER IS MISSING	231	RENDERING PROVIDER NUMBER IS MISSING-THE ENTIRE NINE DIGIT NUMBER MUST BE USED
232	RENDERING PHYS NUMBER NOT IN VALID FORMAT	232	RENDERING PROVIDER NUMBER IS INVALID-THE ENTIRE NINE DIGIT NUMBER MUST BE USED

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
233	UNITS OF SERVICE MISSING	233	THE "UNITS OF SERVICE" IS MISSING-THE UNITS SHOULD BE A WHOLE NUMBER FROM "1" T
234	PROCEDURE CODE MISSING	234	THE PROCEDURE CODE FOR THE DETAIL LINE ITEM(S) IS MISSING. PLEASE USE A HCPC O
235	PROCEDURE CODE NOT IN VALID FORMAT	235	THE PROCEDURE CODE IS NOT IN A VALID FORMAT. PLEASE USE A CPT OR HCPC CODE AND
236	DETAIL "FROM" DATE OF SERVICE MISSING	236	THE DETAIL LINE "FROM" DATE OF SERVICE IS MISSING-THE CORRECT FORMAT IS MMDDYY.
237	"FROM" DATE OF SERVICE INVALID	237	THE DETAIL LINE "FROM" DATE OF SERVICE IS NOT IN THE CORRECT FORMAT-THE CORRECT
238	RECIPIENT NAME IS MISSING	238	RECIPIENT'S NAME MISSING-THE RECIPIENT'S NAME SHOULD REFLECT THE NAME LISTED ON
239	THE DETAIL "TO" DATE OF SERVICE IS MISSING.	239	THE DETAIL LINE "TO" DATE OF SERVICE IS MISSING-THE CORRECT FORMAT IS MMDDYY.
240	THE DETAIL "TO" DATE IS INVALID	240	THE DETAIL LINE "TO" DATE OF SERVICE IS NOT IN THE CORRECT FORMAT-THE CORRECT F
241	ACCIDENT INDICATOR IS INVALID	241	ACCIDENT INDICATOR IS INVALID-PLEASE CHECK THE YES OR NO BLOCK AND INDICATE THE
242	SECONDARY DIAGNOSIS CODE INVALID FORMAT	242	THE SECONDARY DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT. IT SHOULD BE THREE
243	RESERVED FOR FUTURE USE	243	RESERVED FOR FUTURE USE
244	THIRD DIAGNOSIS CODE INVALID	244	THE THIRD DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT-IT SHOULD BE THREE TO FIV
245	RESERVED FOR FUTURE USE.	245	RESERVED FOR FUTURE USE

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
246	FOURTH DIAGNOSIS CODE INVALID	246	THE FOURTH DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT-IT SHOULD BE THREE TO FI
248	PLACE OF SERVICE IS MISSING	248	THE PLACE OF SERVICE CODE IS MISSING-THE CORRECT FORMAT SHOULD BE TWO NUMERIC D
249	PLACE OF SERVICE IS INVALID	249	THE PLACE OF SERVICE CODE IS INVALID-THE CORRECT FORMAT SHOULD BE TWO NUMERIC D
250	CLAIM HAS NO DETAILS	250	YOUR CLAIM WAS SUBMITTED WITHOUT ANY VALID DETAIL LINES-PLEASE VERIFY AND RESUB
251	FIRST MODIFIER INVALID	251	THE FIRST MODIFIER IS NOT VALID-PLEASE REFER TO YOUR PROVIDER MANUAL TO VERIFY
252	SECOND MODIFIER INVALID	252	THE SECOND MODIFIER IS NOT VALID-PLEASE REFER TO YOUR PROVIDER MANUAL TO VERIFY
253	THIRD MODIFIER INVALID	253	THE THIRD MODIFIER IS NOT VALID-PLEASE REFER TO YOUR PROVIDER MANUAL TO VERIFY
254	BILLING PROVIDER LOCATION CODE MISSING	254	BILLING PROVIDER'S LOCATION CODE MISSING-PLEASE PROVIDE AND RESUBMIT.
255	BILLING PROVIDER LOCATION CODE INVALID	255	BILLING PROVIDER'S LOCATION CODE IS INVALID-THE LOCATION CODE SHOULD BE AN ALPH
256	SPENDDOWN APPLIES - SUBMIT 8A FOR DATES ON CLAIM.	256	THIS SERVICE IS NOT PAYABLE-RECIPIENT SPENDDOWN LIABILITY NOT MET. PLEASE VERI
257	SPENDDOWN APPLIES - SUBMIT 8A FOR DATES ON CLAIM.	257	THIS SERVICE IS NOT PAYABLE-RECIPIENT SPENDDOWN LIABILITY NOT MET. PLEASE VERI
258	PRIMARY DIAGNOSIS CODE MISSING	258	PRIMARY DIAGNOSIS CODE IS MISSING-PLEASE PROVIDE AND RESUBMIT.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
260	UNITS OF SERVICE NOT IN VALID FORMAT	260	UNITS OF SERVICE BLANK OR INVALID-PLEASE VERIFY AND RESUBMIT.
261	TOOTH NUMBER MISSING	261	THE TOOTH NUMBER OR LETTER IS MISSING-THE TOOTH NUMBER OR LETTER IS REQUIRED FO
262	TOOTH NUMBER INVALID	262	THE TOOTH NUMBER IS INVALID-THE TOOTH NUMBER OR LETTER IS REQUIRED FOR EXTRACTI
263	TOOTH SURFACE CODE INVALID	263	ONE OR MORE OF THE TOOTH SURFACE CODES BILLED IS INVALID. THE MINIMUM NUMBER O
264	THE DATE OF SERVICE IS MISSING	264	THE DATE OF SERVICE IS MISSING-THE CORRECT FORMAT IS MMDDYY. PLEASE PROVIDE AN
265	THE DATE OF SERVICE IS INVALID	265	THE DATE OF SERVICE IS NOT IN THE CORRECT FORMAT-THE CORRECT FORMAT IS MMDDYY.
266	INSUFFICIENT NUMBER OF VALID TOOTH SURFACE CODES	266	THE NUMBER OF VALID TOOTH SURFACE CODES PRESENT DOES NOT MEET THE MINIMUM NUMBE
268	BILLED AMOUNT MISSING	268	THE BILLED AMOUNT IS MISSING-PLEASE PROVIDE AND RESUBMIT.
269	BILLED AMOUNT INVALID	269	THE BILLED AMOUNT IS NOT IN A VALID FORMAT-IT SHOULD BE NUMERIC DIGITS. PLEASE
270	TOTAL BILLED AMOUNT MISSING	270	THE BILLED AMOUNT IS MISSING-PLEASE PROVIDE AND RESUBMIT.
271	TOTAL BILLED AMOUNT INVALID	271	THE TOTAL AMOUNT IS NOT IN A VALID FORMAT-IT SHOULD BE THE SUM OF THE AMOUNT(S)
272	PRIMARY DIAGNOSIS CODE INVALID	272	THE PRIMARY DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT-PLEASE VERIFY AND RESUB
273	TYPE OF BILL MISSING	273	THE TYPE OF BILL IS MISSING-PLEASE PROVIDE

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			AND RESUBMIT.
274	TYPE OF BILL CODE INVALID	274	THE TYPE OF BILL CODE IS NOT VALID-IT SHOULD BE THREE NUMERIC DIGITS. PLEASE P
275	ADMIT DATE MISSING	275	THE ADMIT DATE IS MISSING-THE CORRECT FORMAT IS MMDDYY. PLEASE PROVIDE AND RES
276	ADMIT DATE INVALID	276	THE ADMIT DATE IS INVALID-THE CORRECT FORMAT IS MMDDYY. PLEASE VERIFY AND RESU
277	ADMIT HOUR INVALID	277	THE ADMIT HOUR IS INVALID-THE CORRECT FORMAT IS TWO DIGITS. PLEASE VERIFY AND
278	ADMIT TYPE MISSING	278	THE ADMIT TYPE IS MISSING-PLEASE PROVIDE AND RESUBMIT.
279	ADMIT TYPE IS INVALID	279	THE ADMIT TYPE IS INVALID-THE CORRECT FORMAT SHOULD BE EITHER A 1, 2, 3, OR 4.
280	PATIENT STATUS IS MISSING	280	THE PATIENT STATUS IS MISSING-PLEASE CHECK THE PROVIDER MANUAL FOR LISTING OF S
281	PATIENT STATUS IS INVALID	281	THE PATIENT STATUS CODE IS NOT VALID-IT SHOULD BE A TWO DIGIT NUMBER. PLEASE V
282	COVERED DAYS MISSING	282	THE NUMBER OF COVERED DAYS IS MISSING FROM YOUR CLAIM-PLEASE PROVIDE AND RESUBM
283	COVERED DAYS INVALID	283	THE NUMBER OF COVERED DAYS IS NOT IN THE CORRECT FORMAT-IT SHOULD BE THE NUMBER
283	COVERED DAYS INVALID	284	THE PRIMARY CONDITION CODE SUBMITTED IS NOT A VALID CODE-PLEASE VERIFY AND RESU
284	PRIMARY CONDITION CODE INVALID	284	THE PRIMARY CONDITION CODE SUBMITTED IS

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			NOT A VALID CODE-PLEASE VERIFY AND RESU
285	SECOND CONDITON CODE INVALID	285	THE SECOND CONDITION CODE SUBMITTED IS NOT A VALID CODE-PLEASE VERIFY AND RESUB
286	THIRD CONDITION CODE INVALID	286	THE THIRD CONDITION CODE SUBMITTED IS NOT A VALID CODE-PLEASE VERIFY AND RESUBM
287	FOURTH CONDITION CODE INVALID	287	THE FOURTH CONDITION CODE SUBMITTED IS NOT A VALID CODE-PLEASE VERIFY AND RESUB
288	FIFTH CONDITION CODE INVALID	288	THE FIFTH CONDTION CODE SUBMITTED IS NOT A VALID CODE-PLEASE VERIFY AND RESUBMI
289	SIXTH CONDITION CODE INVALID	289	THE SIXTH CONDTION CODE SUBMITTED IS NOT A VALID CODE-PLEASE VERIFY AND RESUBMI
290	SEVENTH CONDITION CODE INVALID	290	THE SEVENTH CONDITION CODE IS NOT A VALID CODE. PLEASE VERIFY AND RESUBMIT.
291	PRIMARY OCCURRENCE CODE INVALID	291	THE PRIMARY OCCURRENCE CODE SUBMITTED IS NOT A VALID CODE. PLEASE VERIFY AND R
292	SECOND OCCURRENCE CODE INVALID	292	THE SECOND OCCURRENCE CODE SUBMITTED IS NOT A VALID CODE. PLEASE VERIFY AND RE
293	THIRD OCCURRENCE CODE INVALID	293	THE THIRD OCCURRENCE CODE SUBMITTED IS NOT A VALID CODE. PLEASE VERIFY AND RES
294	FOURTH OCCURRENCE CODE INVALID	294	THE FOURTH OCCURRENCE CODE SUBMITTED IS NOT A VALID CODE. PLEASE VERIFY AND RE
295	DATE FOR PRIMARY OCCURRENCE CODE MISSING	295	THE DATE FOR THE PRIMARY OCCURRENCE CODE IS MISSING. PLEASE VERIFY AND RESUBMI
296	DATE FOR PRIMARY OCCURRENCE CODE INVALID FORMAT	296	THE DATE FOR THE PRIMARY OCCURRENCE CODE IS INVALID. PLEASE VERIFY AND RESUBMI

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
297	DATE FOR SECOND OCCURRENCE CODE MISSING	297	THE DATE FOR THE SECOND OCCURRENCE CODE IS MISSING. PLEASE VERIFY AND RESUBMIT
298	DATE FOR SECOND OCCURRENCE CODE INVALID	298	THE DATE FOR THE SECOND OCCURRENCE CODE IS INVALID. PLEASE VERIFY AND RESUBMIT
299	DATE FOR THIRD OCCURRENCE CODE MISSING	299	THE DATE FOR THE THIRD OCCURRENCE CODE IS MISSING. PLEASE VERIFY AND RESUBMIT.
300	DATE FOR THIRD OCCURRENCE CODE INVALID	300	THE DATE FOR THE THIRD OCCURRENCE CODE IS INVALID. PLEASE VERIFY AND RESUBMIT.
301	DATE FOR FOURTH OCCURRENCE CODE MISSING	301	THE DATE FOR THE FOURTH OCCURRENCE CODE IS MISSING. PLEASE VERIFY AND RESUBMIT
302	DATE FOR FOURTH OCCURRENCE CODE INVALID	302	THE DATE FOR THE FOURTH OCCURRENCE CODE IS INVALID. PLEASE VERIFY AND RESUBMIT
303	PRIMARY VALUE CODE INVALID	303	PRIMARY VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
304	SECOND VALUE CODE INVALID	304	SECOND VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
305	THIRD VALUE CODE INVALID	305	THIRD VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
306	FOURTH VALUE CODE INVALID	306	FOURTH VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
307	FIFTH VALUE CODE INVALID	307	FIFTH VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
308	SIXTH VALUE CODE INVALID	308	SIXTH VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
309	SEVENTH VALUE CODE INVALID	309	SEVENTH VALUE CODE INVALID. PLEASE VERIFY

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			AND RESUBMIT.
310	EIGHTH VALUE CODE INVALID	310	THE EIGHTH VALUE CODE IS NOT A VALID CODE. PLEASE VERIFY AND RESUBMIT.
311	NINTH VALUE CODE INVALID	311	NINTH VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
312	TENTH VALUE CODE INVALID	312	TENTH VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
313	ELEVENTH VALUE CODE INVALID	313	ELEVENTH VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
314	TWELFTH VALUE CODE INVALID	314	TWELFTH VALUE CODE INVALID. PLEASE VERIFY AND RESUBMIT.
315	PRIMARY VALUE CODE AMOUNT MISSING	315	PRIMARY VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
316	PRIMARY VALUE CODE AMOUNT INVALID	316	PRIMARY VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
317	SECOND VALUE CODE AMOUNT MISSING	317	SECOND VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
318	SECOND VALUE CODE AMOUNT INVALID	318	SECOND VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
319	THIRD VALUE CODE AMOUNT MISSING	319	THIRD VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
320	THIRD VALUE CODE AMOUNT INVALID	320	THIRD VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
321	FOURTH VALUE CODE AMOUNT MISSING	321	FOURTH VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
322	FOURTH VALUE CODE AMOUNT INVALID	322	FOURTH VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
323	FIFTH VALUE CODE AMOUNT MISSING	323	FIFTH VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
324	FIFTH VALUE CODE AMOUNT INVALID	324	FIFTH VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
325	SIXTH VALUE CODE AMOUNT MISSING	325	SIXTH VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
326	SIXTH VALUE CODE AMOUNT INVALID	326	SIXTH VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
327	SEVENTH VALUE CODE AMOUNT MISSING	327	SEVENTH VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
328	SEVENTH VALUE CODE AMOUNT INVALID	328	SEVENTH VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
329	EIGHTH VALUE CODE AMOUNT MISSING	329	EIGHTH VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
330	EIGHTH VALUE CODE AMOUNT INVALID	330	EIGHTH VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
331	NINTH VALUE CODE AMOUNT MISSING	331	NINTH VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
332	NINTH VALUE CODE AMOUNT INVALID	332	NINTH VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
333	TENTH VALUE CODE AMOUNT MISSING	333	TENTH VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
334	TENTH VALUE CODE AMOUNT INVALID	334	TENTH VALUE CODE AMOUNT INVALID. PLEASE

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			VERIFY AND RESUBMIT.
335	ELEVENTH VALUE CODE AMOUNT MISSING	335	ELEVENTH VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
336	ELEVENTH VALUE CODE AMOUNT INVALID	336	ELEVENTH VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
337	TWELFTH VALUE CODE AMOUNT MISSING	337	TWELFTH VALUE CODE AMOUNT MISSING. PLEASE VERIFY AND RESUBMIT.
338	TWELFTH VALUE CODE AMOUNT INVALID	338	TWELFTH VALUE CODE AMOUNT INVALID. PLEASE VERIFY AND RESUBMIT.
339	REVENUE CODE IS MISSING	339	REVENUE CODE IS MISSING. PLEASE VERIFY AND RESUBMIT.
340	REVENUE CODE IS INVALID	340	REVENUE CODE IS INVALID. PLEASE VERIFY AND RESUBMIT.
341	PRIMARY PAYER CODE IS MISSING	341	THERE IS NO PRIMARY PAYER ENTERED ON THE CLAIM. PLEASE VERIFY AND RESUBMIT.
342	CERTIFICATION CODE MISSING	342	THE CERTIFICATION CODE IS MISSING. PLEASE VERIFY AND RESUBMIT.
343	CERTIFICATION CODE INVALID	343	THE CERTIFICATION CODE IS INVALID. PLEASE VERIFY AND RESUBMIT.
344	RESERVED FOR FUTURE USE	344	THE THIRD PAYER CODE IS NOT VALID. PLEASE VERIFY AND RESUBMIT.
345	PAYER PROVIDER NUMBER IS MISSING.	345	THE PAYER PROVIDER NUMBER IS MISSING- PLEASE VERIFY AND RESUBMIT.
346	PAYER PRIOR PAYMENT IS MISSING	346	A PAYER OTHER THAN THE INDIANA HEALTH COVERAGE PROGRAM IS INDICATED IN THE FIRS

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
347	PAYER PRIOR PAYMENT IS INVALID	347	A PAYER OTHER THAN THE INDIANA HEALTH COVERAGE PROGRAM IS INDICATED IN THE FIRS
348	PAYER PRIOR PAYMENT IS MISSING (LINE 2)	348	RESERVED FOR FUTURE USE.
349	PAYER PRIOR PAYMENT IS INVALID (LINE 2)	348	RESERVED FOR FUTURE USE.
349	PAYER PRIOR PAYMENT IS INVALID (LINE 2)	349	RESERVED FOR FUTURE USE
350	RESERVERD FOR FUTURE USE.	350	RESERVED FOR FUTURE USE
351	RESERVED FOR FUTURE USE.	351	RESERVED FOR FUTURE USE
352	ESTIMATED AMOUNT DUE IS MISSING	352	THE INDIANA HEALTH COVERAGE PROGRAMS ESTIMATED AMOUNT DUE ON THE FIRST PAYER L
353	ESTIMATED AMOUNT DUE IS INVALID (LINE 1)	353	THE INDIANA HEALTH COVERAGE PROGRAMS ESTIMATED AMOUNT DUE ON THE FIRST PAYER LI
354	AMOUNT DUE FROM PATIENT IS INVALID.	354	THE AMOUNT DUE FROM PATIENT IS NOT VALID. PLEASE VERIFY AMOUNT AND RESUBMIT TH
355	FIFTH DIAGNOSIS CODE INVALID	355	THE FIFTH DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND RESUB
356	SIXTH DIAGNOSIS CODE INVALID	356	THE SIXTH DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND RESUB
357	SEVENTH DIAGNOSIS CODE INVALID	357	THE SEVENTH DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND RES
358	EIGHTH DIAGNOSIS CODE INVALID	358	THE EIGHTH DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND RESU
359	NINTH DIAGNOSIS CODE INVALID	359	THE NINTH DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND RESUB

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
360	ADMITTING DIAGNOSIS MISSING	360	THE ADMITTING DIAGNOSIS CODE IS MISSING. PLEASE VERIFY AND RESUBMIT THE CLAIM
361	ADMITTING DIAGNOSIS CODE INVALID	361	THE ADMITTING DIAGNOSIS CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND R
362	E CODE INVALID	362	THE "E" CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND RESUBMIT.
363	PRINCIPAL PROCEDURE CODE INVALID	363	THE PRINCIPAL PROCEDURE CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND R
364	PRINCIPAL PROCEDURE DATE MISSING	364	THE PRINCIPAL PROCEDURE DATE IS MISSING. PLEASE VERIFY AND RESUBMIT.
365	PRINCIPAL PROCEDURE DATE INVALID	365	THE PRINCIPAL PROCEDURE DATE IS NOT IN THE VALID FORMAT. THE CORRECT FORMAT IS
366	FIRST OTHER PROCEDURE CODE INVALID	366	THE FIRST OTHER PROCEDURE CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND
367	FIRST OTHER PROCEDURE DATE MISSING	367	THE FIRST OTHER PROCEDURE CODE DATE IS MISSING. PLEASE VERIFY AND RESUBMIT.
368	FIRST OTHER PROCEDURE DATE INVALID	368	THE FIRST OTHER PROCEDURE DATE IS NOT IN THE VALID FORMAT. THE CORRECT FORMAT I
369	SECOND OTHER PROCEDURE CODE INVALID	369	THE SECOND OTHER PROCEDURE CODE IS NOT IN THE CORRECT FORMAT. PLEASE VERIFY AND
370	SECOND OTHER PROCEDURE DATE MISSING	370	THE SECOND OTHER PROCEDURE CODE DATE IS MISSING
371	SECOND OTHER PROCEDURE DATE INVALID	371	THE SECOND OTHER PROCEDURE DATE IS NOT IN THE VALID FORMAT-PLEASE VERIFY AND RE
372	THIRD OTHER PROCEDURE CODE INVALID	372	THE THIRD OTHER PROCEDURE CODE IS NOT IN

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			THE CORRECT FORMAT-PLEASE VERIFY AND R
373	THIRD OTHER PROCEDURE DATE MISSING	373	THE THIRD OTHER PROCEDURE DATE IS MISSING-PLEASE VERIFY AND RESUBMIT.
374	THIRD OTHER PROCEDURE DATE INVALID	374	THE THIRD OTHER PROCEDURE DATE IS NOT IN THE CORRECT FORMAT-PLEASE VERIFY AND R
375	FOURTH OTHER PROCEDURE CODE INVALID	375	THE FOURTH OTHER PROCEDURE CODE IS NOT IN THE CORRECT FORMAT-PLEASE VERIFY AND
376	FOURTH OTHER PROCEDURE DATE MISSING	376	THE FOURTH OTHER PROCEDURE DATE IS MISSING-PLEASE VERIFY AND RESUBMIT.
377	FOURTH OTHER PROCEDURE DATE INVALID	377	THE FOURTH OTHER PROCEDURE DATE IS NOT IN THE VALID FORMAT-PLEASE VERIFY AND RE
378	FIFTH OTHER PROCEDURE CODE INVALID	378	THE FIFTH OTHER PROCEDURE CODE IS NOT IN THE CORRECT FORMAT-PLEASE VERIFY AND R
379	FIFTH OTHER PROCEDURE DATE MISSING	379	THE FIFTH OTHER PROCEDURE DATE IS MISSING-PLEASE VERIFY AND RESUBMIT.
380	FIFTH OTHER PROCEDURE DATE INVALID	380	THE FIFTH OTHER PROCEDURE DATE IS NOT IN THE VALID FORMAT-PLEASE VERIFY AND RES
381	ATTENDING PHYSICIAN LICENSE NUMBER MISSING	381	ATTENDING PHYSICIAN LICENSE NUMBER IS MISSING-PLEASE VERIFY AND RESUBMIT.
382	ATTENDING PHYSICIAN ID INVALID	382	ATTENDING PHYSICIAN PROVIDER NUMBER IS INVALID-PLEASE VERIFY AND RESUBMIT.
383	FIRST OTHER PHYSICIAN ID INVALID	383	FIRST OTHER PHYSICIAN PROVIDER NUMBER IS INVALID-PLEASE VERIFY AND RESUBMIT.
384	SECOND OTHER PHYSICIAN ID INVALID	384	SECOND OTHER PHYSICIAN PROVIDER NUMBER IS INVALID-PLEASE VERIFY AND RESUBMIT.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
385	SPENDDOWN DATE SAME AS DOS	385	THE DATE OS SERVICE ON THIS CLAIM MATCHES THE RECIPIENTS SPENDDOWN MET DATE FOR
385	SPENDDOWN DATE SAME AS DOS	9603	THE DATE OF SERVICE ON THIS CLAIM MATCHES THE RECIPIENT'S SPENDDOWN MET DATE FOR
386	SPENDDOWN DATE SAME AS DATE OF SERVICE	386	THE DATE OF SERVICE ON THIS CLAIM MATCHES THE RECIPIENT'S SPENDDOWN MET DATE FOR
387	SPENDDOWN NOT MET FOR THE MONTH	387	THIS SERVICE IS NOT PAYABLE. THE RECIPIENT HAS NOT SATISFIED SPENDDOWN FOR THE
388	SPENDDOWN NOT MET FOR THE MONTH	388	THIS SERVICE IS NOT PAYABLE. THE RECIPIENT HAS NOT SATISFIED SPENDDOWN FOR THE
389	REVENUE CODE REQUIRES A CORRESPONDING HCPCS/CPT-4	389	THE REVENUE CODE SUBMITTED REQUIRES A CORRESPONDING HCPCS CODE.
391	QMB ALSO - SPENDDOWN NOT MET	391	THIS SERVICE NOT PAYABLE, RECIPIENT IS QMB-ALSO AND SPENDDOWN HAS NOT BEEN MET.
392	QMB ALSO - SPENDDOWN NOT MET	392	THIS SERVICE NOT PAYABLE, RECIPIENT IS QMB-ALSO AND SPENDDOWN HAS NOT BEEN MENT
392	QMB ALSO - SPENDDOWN NOT MET	9660	THIS SERVICE IS NOT PAYABLE, RECIPIENT IS QMB ALSO AND SPENDDOWN HAS NOT BEEN M
393	MEDICARE DEDUCTIBLE AMOUNT MISSING	393	RESERVED FOR FUTURE USE
394	MEDICARE CO-INSURANCE AMOUNT MISSING	394	RESERVED FOR FUTURE USE
395	STATEMENT COVERS PERIOD "FROM" DATE MISSING	395	THE "FROM" SERVICE DATE IS MISSING FROM YOUR CLAIM. PLEASE VERIFY AND RESUBMIT.
396	STATEMENT COVERS PERIOD "FROM" DATE INVALID	396	THE "FROM" SERVICE DATE ON YOUR CLAIM IS NOT IN THE CORRECT FORMAT. PLEASE ENT

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
397	THE STATEMENT COVERS PERIOD "THROUGH" DATE IS MISS	397	THE "THROUGH" SERVICE DATE IS MISSING FROM YOUR CLAIM-PLEASE VERIFY AND RESUBMI
398	THE STATEMENT COVERS PERIOD "THROUGH" DATE IS INVA	398	THE "THROUGH" SERVICE DATE ON YOUR CLAIM IS NOT IN THE CORRECT FORMAT. PLEASE
399	REFERRING PROVIDER I.D.# IS NOT IN A VALID FORMAT	399	THIS CLAIM CANNOT BE PROCESSED FOR PAYMENT. THE REFERRING PROVIDER NUMBER IS N
400	UNITS OF SERVICE MUST BE GREATER THAN ZERO	400	UNITS OF SERVICE BLANK OR INVALID-PLEASE RESUBMIT WITH WHOLE UNITS.
401	NET CHARGE IS MISSING	401	NET CHARGE IS MISSING
402	EXPECTED DELIVERY DATE NOT IN VALID FORMAT	402	EXPECTED DELIVERY DATE NOT IN VALID FORMAT. PLEASE ENTER DATE IN MMDDYY FORMAT
403	HOSPITAL "FROM" DATE INVALID	403	THE "FROM" SERVICE DATE IS NOT IN THE CORRECT FORMAT. PLEASE ENTER IN MMDDYY
404	HOSPITAL "THRU" DATE INVALID	404	THE "THROUGH" SERVICE DATE IS NOT IN THE CORRECT FORMAT. PLEASE ENTER IN MMDD
405	FIFTH OCCURRENCE CODE INVALID	405	THE FIFTH OCCURRENCE CODE IS NOT A VALID CODE ON THE OCCURRENCE CODE LIST. PLE
406	SIXTH OCCURRENCE CODE INVALID	406	THE SIXTH OCCURRENCE CODE IS NOT A VALID CODE ON THE OCCURRENCE CODE LIST. PLE
407	SEVENTH OCCURRENCE CODE INVALID	407	THE SEVENTH OCCURRENCE CODE IS NOT A VALID CODE ON THE OCCURRENCE CODE LIST. P
408	EIGHTH OCCURRENCE CODE INVALID	408	THE EIGHTH OCCURRENCE CODE IS NOT A VALID CODE ON THE OCCURRENCE CODE LIST. PL

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
409	NINTH OCCURRENCE CODE INVALID	409	THE NINTH OCCURRENCE CODE IS NOT A VALID CODE ON THE OCCURRENCE CODE LIST. PLEA
410	TENTH OCCURRENCE CODE INVALID	410	THE TENTH OCCURRENCE CODE IS NOT A VALID CODE ON THE OCCURRENCE CODE LIST. PLEA
411	DATE FOR FIFTH OCCURRENCE CODE MISSING	411	THE DATE FOR THE FIFTH OCCURRENCE CODE IS MISSING. PLEASE RESUBMIT WITH PROPER
412	DATE FOR FIFTH OCCURRENCE CODE INVALID	412	THE DATE FOR THE FIFTH OCCURRENCE CODE IS NOT A VALID DATE. PLEASE RESUBMIT WI
413	DATE FOR SIXTH OCCURRENCE CODE MISSING	413	THE DATE FOR THE SIXTH OCCURRENCE CODE IS MISSING. PLEASE RESUBMIT WITH THE PR
414	DATE FOR SIXTH OCCURRENCE CODE INVALID	414	THE DATE FOR THE SIXTH OCCURRENCE CODE IS NOT A VALID DATE. PLEASE RESUBMIT WI
415	DATE FOR SEVENTH OCCURRENCE CODE MISSING	415	THE DATE FOR THE SEVENTH OCCURRENCE CODE IS MISSING. PLEASE RESUBMIT WITH THE
416	DATE FOR SEVENTH OCCURRENCE CODE INVALID	416	THE DATE FOR THE SEVENTH OCCURRENCE CODE IS NOT A VALID DATE. PLEASE RESUBMIT
417	DATE FOR EIGHTH OCCURRENCE CODE MISSING	417	THE DATE FOR THE EIGHTH OCCURRENCE CODE IS MISSING. PLEASE RESUBMIT WITH THE P
418	DATE FOR EIGHTH OCCURRENCE CODE INVALID	418	THE DATE FOR THE EIGHTH OCCURRENCE CODE IS NOT A VALID DATE. PLEASE RESUBMIT W
419	FROM DATE OF SERVICE FOR NINTH OCCURRENCE CODE MIS	419	THE "FROM" DATE OF SERVICE FOR THE NINTH OCCURRENCE CODE IS MISSING. PLEASE RE
420	FROM DATE OF SERVICE FOR NINTH OCCURRENCE CODE INV	420	THE "FROM" DATE OF SERVICE FOR THE NINTH OCCURRENCE CODE IS NOT A VALID DATE.
421	TO DATE OF SERVICE FOR NINTH OCCURRENCE	421	THE "TO" DATE OF SERVICE FOR THE NINTH

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
	CODE MISSI		OCCURRENCE CODE IS MISSING. PLEASE RESU
422	TO DATE OF SERVICE FOR NINTH OCCURRENCE CODE INVAL	422	THE "TO" DATE OF SERVICE FOR THE NINTH OCCURRENCE CODE IS NOT A VALID DATE. PL
423	FROM DATE OF SERVICE FOR TENTH OCCURRENCE CODE MIS	423	THE "FROM" DATE OF SERVICE FOR THE TENTH OCCURRENCE CODE IS MISSING. PLEASE RE
424	FROM DATE OF SERVICE FOR TENTH OCCURRENCE CODE INV	424	THE "FROM" DATE OF SERVICE FOR THE TENTH OCCURRENCE CODE IS NOT A VALID DATE.
425	TO DATE OF SERVICE FOR TENTH OCCURRENCE CODE MISSI	425	THE "TO" DATE OF SERVICE FOR THE TENTH OCCURRENCE CODE IS MISSING. PLEASE RESU
426	TO DATE OF SERVICE FOR TENTH OCCURRENCE CODE INVAL	426	THE "TO" DATE OF SERVICE FOR THE TENTH OCCURRENCE CODE IS NOT A VALID DATE. PL
427	QUANTITY DISPENSED IS MISSING	427	THE QUANTITY DISPENSED INFORMATION IS MISSING. PLEASE VERIFY INFORMATION AND R
428	QUANTITY DISPENSED IS INVALID	427	THE QUANTITY DISPENSED INFORMATION IS MISSING. PLEASE VERIFY INFORMATION AND R
429	590 CHARGES LESS THAN $150.00	429	THE TOTAL CHARGES SUBMITTED ARE LESS THAN THE $150.00 MINIMUM FOR THE 590 PROGR
430	PARTIAL UNITS BILLED	430	PARTIAL UNITS MAY NOT BE BILLED. PLEASE RESUBMIT IN WHOLE NUMBERS.
431	RESERVED FOR FUTURE USE	431	PAYMENT HAS BEEN CUTBACK BY THE PATIENT LIABILITY DEVIATION NOTED ON THE CLAIM
432	INVALID MCO INDENTIFICATION NUMBER	432	INVALID MCO IDENTIFICATION NUMBER-PLEASE VERIFY AND RESUBMIT.
433	DEDUCTIBLE AMOUNT INVALID	433	THE DEDUCTIBLE AMOUNT IS NOT IN THE VALID FORMAT. PLEASE RESUBMIT IN ALL NUMER

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
434	COINSURANCE AMOUNT INVALID	434	THE COINSURANCE AMOUNT IS NOT IN THE VALID FORMAT. PLEASE RESUBMIT IN ALL NUME
435	BLOOD DEDUCTIBLE AMOUNT INVALID	435	THE BLOOD DEDUCTIBLE AMOUNT IS NOT IN THE VALID FORMAT. PLEASE RESUBMIT IN ALL
436	TOTAL MEDICARE ALLOWED AMOUNT INVALID	436	THE TOTAL MEDICARE ALLOWED AMOUNT IS NOT IN THE VALID FORMAT. PLEASE RESUBMIT
437	PSYCH ADJUSTMENT AMOUNT INVALID	437	THE PSYCH ADJUSTMENT AMOUNT IS NOT IN THE VALID FORMAT. PLEASE RESUBMIT IN ALL
438	THE PATIENT DEDUCTIBLE AMOUNT IS INVALID	438	THE PATIENT SPENDDOWN AMOUNT IS NOT IN THE VALID FORMAT-PLEASE VERIFY AND RESUB
439	HOSPICE SERVICES BEING BILLED (MANUAL PAYOUT)	439	HOSPICE SERVICES BEING BILLED. (MANUAL PAYOUT)
440	EMERGENCY INDICATOR INVALID(HEADER)	207	INVALID EMERGENCY INDICATOR CODE-IF THIS WAS AN EMERGENCY, IT SHOULD BE "Y" FOR
441	PREGNANCY INDICATOR INVALID(HEADER)	208	INVALID PREGNANCY INDICATOR CODE-IT SHOULD BE "P" IF THE PATIENT IS PREGNANT AN
499	CCF NOT RETURNED WITHIN 45 DAYS	499	CLAIM DENIED. CCF NOT RETURNED WITH PROPER CORRECTIONS WITHIN 45 DAYS.
500	DATE PRESCRIBED AFTER BILLING DATE	500	DATE PRESCRIBED IS AFTER THE BILLING DATE. PLEASE VERIFY PRESCRIBED DATE AND R
502	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	502	DISPENSED DATE IS EARLIER THAN PRESCRIBED DATE. PLEASE VERIFY AND RESUBMIT.
503	DATE DISPENSED AFTER BILLING DATE	503	CLAIM CANNOT BE BILLED BEFORE THE PRESCRIPTION IS DISPENSED. PLEASE VERIFY DIS
504	EXPECTED DELIVERY DATE IS MISSING	504	THE EXPECTED DATE OF DELIVERY IS MISSING-

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			PLEASE SUBMIT WITH PROPER DATE IN FORM
505	THIRD PARTY PAYMENT AMOUNT MORE THAN CLAIM CHARGE	505	THE THIRD PARTY AMOUNT IS MORE THAN THE TOTAL CLAIM CHARGE; THEREFORE, NO MEDIC
506	DATE BILLED AFTER ICN DATE	506	BILLED DATE ENTERED IS AFTER EDS RECEIVED THE CLAIM-PLEASE VERIFY AND RESUBMIT.
507	THE "FROM" DATE IS AFTER THE "TO" DATE	507	THE "FROM" DATE IS AFTER THE "TO" DATE OF SERVICE. PLEASE VERIFY AND RESUBMIT.
508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL LINE C	508	THE SUM OF THE INDIVIDUAL LINE CHARGES SUBMITTED ON THIS CLAIM DOES NOT EQUAL
509	NET CHARGE OUT OF BALANCE	509	THIS CLAIM WAS SUBMITTED WITH AN INCOMPLETE OR INVALID NET CHARGE. THE ESTIMAT
510	THE "FROM" DATE IS AFTER THE "TO" DATE FOR NINTH O	510	THE "FROM" DATE IS AFTER THE "TO" DATE OF SERVICE FOR THE NINTH OCCURRENCE COD
511	THE "FROM" DATE IS AFTER THE "TO" DATE FOR THE TEN	510	THE "FROM" DATE IS AFTER THE "TO" DATE OF SERVICE FOR THE NINTH OCCURRENCE COD
511	THE "FROM" DATE IS AFTER THE "TO" DATE FOR THE TEN	511	THE "FROM" DATE IS AFTER THE "TO" DATE OF SERVICE FOR THE TENTH OCCURRENCE CODE
512	CLAIM PAST FILING LIMIT	512	YOUR CLAIM WAS FILED PAST THE FILING TIME LIMIT WITHOUT ACCEPTABLE DOCUMENTATI
513	RECIPIENT NAME AND NUMBER DISAGREE	513	RECIPIENT'S NUMBER DOES NOT MATCH THE RECIPIENT'S NAME. PLEASE VERIFY AND RESU
514	HEADER THRU DATE OF SERVICE AFTER ICN DATE	514	CLAIM CANNOT BE BILLED BEFORE THE SERVICE IS RENDERED.
515	HOME HEALTH OVERHEAD FEE NOT ON FILE	515	THE OVERHEAD FEE IS NOT ON FILE FOR THE

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
	FOR OCCURRENC		DATES OF SERVICE INDICATED. PLEASE VER
516	OCCURRENCE CODE DATE DOES NOT MATCH CLAIM DETAI	516	THE OCCURRENCE CODE DATES DO NOT MATCH THE CLAIM DETAIL DATES. PLEASE VERIFY A
517	OCCURRENCE SPAN DATES DO NOT MATCH CLAIM DETAIL DA	517	THE OCCURRENCE CODE DATES DO NOT MATCH ANY OF THE SERVICE DATES BILLED ON THE D
518	COVERED DAYS EXCEED STATEMENT PERIOD	518	THE COVERED DAYS ENTERED DO NOT MATCH THE STATEMENT PERIOD DATES. PLEASE VERIFY
519	ADMIT DATE IS AFTER THE STATEMENT PERIOD "FROM" DA	519	THE ADMIT DATE MUST BE EQUAL TO OR BEFORE THE STATEMENT PERIOD "FROM" DATE. PLE
520	INVALID REVENUE CODE/PROCEDURE CODE COMBINATION	520	INVALID REVENUE CODE AND PROCEDURE CODE COMBINATION - PLEASE VERIFY AND RESUBMI
521	THRU DATE OF SERVICE LATER THAN DISCHARGE DATE	521	THE "THRU" DATE OF SERVICE IS AFTER THE DISCHARGE DATE. PLEASE VERIFY AND RESU
522	PATIENT STATUS AND OCCURRENCE CODE DO NOT MATCH	522	THE PATIENT STATUS CODE INDICATES A DISCHARGE BUT NO DISCHARGE OCCURRENCE CODE
523	DISCHARGE DATE GREATER THAN ICN DATE	523	THIS CLAIM CANNOT BE SUBMITTED UNTIL AFTER THE SERVICES HAVE BEEN RENDERED.
524	OCCURRENCE CODE DATE CANNOT BE WITHIN THE OCCURREN	524	OCCURRENCE CODE DATE CANNOT BE WITHIN THE OCCURRENCE SPAN DATE-PLEASE VERIFY AN
525	DUPLICATE OCCURRENCE DATES BILLED	525	DUPLICATE OCCURRENCE DATES BILLED-ONLY ONE OCCURRENCE CODE MAY BE BILLED PER DA
526	THE STATEMENT COVERS PERIOD "FROM" DATE IS AFTER T	526	THE STATEMENT COVERS PERIOD "FROM" DATE IS OUT OF SEQUENCE WITH THE "THROUGH" D

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
527	DATE OF SERVICE AFTER ICN DATE	527	CLAIM CANNOT BE BILLED BEFORE THE SERVICE IS RENDERED
528	INVALID DISCHARGE STATUS	528	INVALID DISCHARGE STATUS-PLEASE VERIFY AND RESUBMIT.
529	SURGERY DATE IS BEFORE THE ADMISSION DATE	529	THE SURGERY DATE IS BEFORE THE ADMISSION DATE-PLEASE VERIFY AND RESUBMIT.
530	SURGERY DATE IS AFTER THE DISCHARGE DATE.	530	THE SURGERY DATE IS AFTER THE DISCHARGE DATE-PLEASE VERIFY AND RESUBMIT.
531	MODIFIER IS MISSING	531	THE MODIFIER TO IDENTIFY THE TRIMESTER BEING BILLED IS MISSING-PLEASE VERIFY AN
532	REVENUE CODE/PROVIDER SPECIALTY MISMATCH	532	BILLING PROVIDER'S SPECIALTY IS NOT APPROVED TO BILL THIS REVENUE CODE-PLEASE V
533	LATE BILLING	533	PAID AS BILLED.
534	PROCEDURE CODE/CLAIM TYPE & TYPE OF BILL	534	PROCEDURE CODE NOT CONSISTENT WITH TYPE OF BILL-PLEASE VERIFY AND RESUBMIT.
535	INVALID EXPECTED DATE OF DELIVERY/TRIMESTER COMBIN	535	THE TRIMESTER BILLED DOES NOT CORRESPOND TO THE EXPECTED DELIVERY DATE-PLEASE V
536	BILLED DATE LESS THAN DATES OF SERVICE ON THE CLAI	536	DATE BILLED IS PRIOR TO THE DATES OF SERVICE ON THE CLAIM-PLEASE VERIFY AND RES
537	REFUND AMOUNT IS GREATER THAN THE ADJUSTED AMOUNT	537	REFUND AMOUNT IS GREATER THAN THE ADJUSTED AMOUNT.
538	REFUND AMOUNT IS LESS THAN ADJUSTED AMOUNT.	538	REFUND AMOUNT IS GREATER THAN THE ADJUSTED AMOUNT.
539	KEYED BUT NOT ACTIVATED	539	KEYED BUT NOT ACTIVATED

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
540	INVALID BATCH SEQUENCE NUMBER	540	CLAIM KEYED BUT NOT ACTIVATED.
541	BATCH SEQUENCE NUMBER ALREADY PROCESSED	541	CLAIM ACTIVATED BUT NOT KEYED.
542	BATCH SEQUENCE NUMBER ALREADY DELETED	542	PRICING BEING REVIEWED.
543	ADJUSTMENT AUTO-DENIAL	543	ADJUSTMENT DENIED BECAUSE OF A FULL REFUND, FULL RECOUPMENT, OR VOIDED CHECK RE
544	ERROR STATUS CODE NOT ENTERED ON ERROR DISPOSTION	544	CLAIM IN REVIEW STATUS.
545	CLAIM PAST FILING LIMIT	545	YOUR CLAIM WAS FILED PAST THE FILING TIME LIMIT WITHOUT ACCEPTABLE DOCUMENTATIO
546	TYPE OF BILL INVALID FOR RECIPIENT LEVEL OF CARE	546	TYPE OF BILL INVALID FOR RECIPIENT'S LEVEL OF CARE-PLEASE VERIFY AND RESUBMIT.
547	HOSPITAL LEAVE BILLED WITHOUT ACCOMMODATION	547	HOSPITAL LEAVE DAYS MUST BE BILLED ON THE SAME CLAIM AS THE ACCOMMODATION DAYS-
548	THERAPEUTIC LEAVE BILLED WITHOUT ACCOMMODATION COD	548	THERAPEUTIC LEAVE DAYS MUST BE BILLED ON THE SAME CLAIM AS THE ACCOMMODATION DA
549	INVALID TYPE OF BILL FOR ANCILLARY SERVICE	549	INVALID TYPE OF BILL FOR ANCILLARY SERVICE.
550	MANUAL DENY OF DETAILS/ADJUSTMENTS	550	THIS PROCEDURE HAS BEEN REPLACED OR DELETED TO REFLECT APPROPRIATE SERVICES REN
551	HOME HEALTH OVERHEAD FEE MISSING FOR DATES OF SERV	551	AN OVERHEAD FEE DID NOT APPEAR ON THE CLAIM FOR DATES OF SERVICE BILLED.
552	HOME HEALTH CLAIM SPANS 07/01/95	552	THE DATES BILLED SPAN. IN ORDER TO PROCESS

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			YOUR CLAIM, YOU MUST SPLIT BILL FOR
553	THIRD PARTY PAYMENT/MEDICARE PAYMENT AMOUNT MORE T	553	THIRD PARTY PAYMENT/MEDICARE PAYMENT IS MORE THAN THE TOTAL CLAIM PAYMENT. NO
554	BILLED DATE LESS THAN DATES OF SERVICE ON THE CLAI	554	DATE BILLED IS PRIOR TO THE DATES OF SERVICE ON THE CLAIM
557	SERVICE NOT COVERED BY CAPITATION RATE	557	SERVICE NOT COVERED BY CAPITATION RATE
558	COINSURANCE AND DEDUCTIBLE AMOUNT MISSING	558	CLAIM SUBMITTED HAS NO COINSURANCE AND DEDUCTIBLE AMOUNT INDICATING THAT THIS I
559	COINSURANCE AMT NOT CORRECT % OF THE TOTAL M'CARE	559	THE COINSURANCE AMOUNT IS NOT THE CORRECT PERCENTAGE OF THE TOTAL MEDICARE ALLO
561	COMBINATION QMB/NON QMB AID CATEGORIES BILLED FOR	561	A QUALIFIED MEDICARE BENEFICIARY RECIPIENT HAS BEEN ENROLLED IN MULTIPLE AID CA
562	TYPE OF BILL/REVENUE CODE MISMATCH	562	HOSPICE SERVICES HAVE INCOMPATIBLE TYPE OF BILL AND REVENUE CODES BEING BILLED.
563	REVENUE CODE/UNITS MISMATCH	563	UNITS BILLED INCOMPATIBLE WITH ALLOWED UNITS FOR THE REVENUE CODE.
564	REVENUE CODE/QMB ALSO ELIGIBILITY COMBINATION INVA	564	THIS REVENUE CODE IS NOT ALLOWED FOR THIS RECIPIENT'S ELIGIBILITY.
565	PAID AMOUNT IS GREATER THAN THE BILLED AMOUNT	565	PAID AMOUNT IS GREATER THAN BILLED AMOUNT
1000	BILLING PROVIDER I.D. NUMBER NOT 0N FILE.	1000	BILLING PROVIDER'S NUMBER IS NOT ON FILE. PLEASE VERIFY PROVIDER NUMBER AND RE
1001	BILLING PROVIDER NOT ELIGIBLE TO BILL ON THIS PGM	1001	BILLING PROVIDER NOT ENROLLED IN PROGRAM BILLED. PLEASE VERIFY PROVIDER NUMBER

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
1002	REND PROV NOT ELIGIBLE TO RENDER SVC ON THIS PGM	1002	RENDERING PROVIDER NOT ENROLLED IN THE PROGRAM BILLED . PLEASE VERIFY PROVIDER
1003	BILLING PROVIDER NOT ELIGIBLE TO BILL ON THIS PRGM	1003	BILLING PROVIDER NOT ENROLLED IN THE PROGRAM BILLED FOR THE DATE OF SERVICE. P
1003	BILLING PROVIDER NOT ELIGIBLE TO BILL ON THIS PRGM	1005	SERVICE DATE PRIOR TO RATE APPROVAL DATE. PLEASE VERIFY DATE AND RESUBMIT.
1004	RENDERING PROVIDER NOT ELIG TO RENDER SVS ON DOS	1004	RENDERING PROVIDER NOT ENROLLED IN THE PROGRAM BILLED FOR THE DATES OF SERVICE.
1005	SERVICE DATE PRIOR TO RATE APPROVAL DATE	1005	SERVICE DATE PRIOR TO RATE APPROVAL DATE. PLEASE VERIFY DATE AND RESUBMIT.
1006	PROVIDER NOT AUTHORIZED TO BILL ANCILLARY	1006	SERVICE DATE BEFORE PROVIDER AUTHORIZED TO BILL ANCILLARY. PLEASE VERIFY DATE
1007	RENDERING PROVIDER NOT ON PROVIDER DATABASE	1007	PROVIDER NUMBER OF THE RENDERING PHYSICIAN IS NOT ON FILE. PLEASE VERIFY PROV
1008	RENDERING PROVIDER MUST HAVE AN INDIVIDUAL NUMBER	1008	THE RENDERING PROVIDER MUST BE AN INDIVIDUAL PROVIDER. PLEASE VERIFY PROVIDER N
1010	RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP	1010	RENDERING PROVIDER IS NOT AN ELIGIBLE MEMBER OF BILLING GROUP. PLEASE VERIFY
1011	RECIPIENT'S PMP IS MISSING	1011	THE RECIPIENT IS ENROLLED IN HOOSIER HEALTHWISE PRIMARY CARE CASE MANAGEMENT PR
1012	REND PROV SPECIALTY NOT ELIGIBLE TO RENDER PROC CD	1012	PROCEDURE BILLED NOT PAYABLE FOR THIS PROVIDER SPECIALTY.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
1012	REND PROV SPECIALTY NOT ELIGIBLE TO RENDER PROC CD	9012	WRONG CLAIM FORM SUBMITTED. PLEASE RESUBMIT ON A UB92 CLAIM FORM.
1013	CLAIM PROVIDER NUMBER/AUTHORIZED PROVIDER NUMBER M	1013	THE BILLING PROVIDER NUMBER SUBMITTED ON THIS CLAIM HAS NOT BEEN PRIOR AUTHORIZ
1014	CLAIM PROV NBR AND AUTH PROV NBR MISMATCH	1014	THE RENDERING PROVIDER NUMBER SUBMITTED ON THIS CLAIM HAS NOT BEEN PRIOR AUTHOR
1015	PROVIDER NOT AUTHORIZED TO RENDER THIS SERVICE FOR	1015	THE RENDERING PROVIDER ON THIS CLAIM IS NOT ON THE LIST OF PROVIDERS AUTHORIZED
1016	NON-PARTICIPATING MANUFACTURER	1016	THIS MANUFACTURER DOES NOT PARTICIPATE IN THE DRUG REBATE PROGRAM.
1017	NO RATE SEGMENT FOR LEVEL OF CARE(CASE MIX)	1017	NO RATE SEGMENT FOR LEVEL OF CARE(CASE MIX)
1018	NO RATE SEGMENT FOR LEVEL OF CARE	1018	NO RATE SEGMENT ON FILE FOR LEVEL OF CARE.
1019	MULTIPLE LEVELS OF CARE PER DIEM ON FILE	1019	MULTIPLE LEVELS OF CARE PER DIEM ON FILE. PLEASE SPLIT CLAIM TO IDENTIFY DIFFE
1020	ATTENDING PHYSICIAN ID NUMBER NOT ON FILE	1020	THE ATTENDING PHYSICIAN ID IS NOT A VALID INDIANA LICENSE NUMBER. PLEASE VERIF
1021	FIRST OTHER PHYSICIAN ID NUMBER NOT ON FILE	1021	THE FIRST OTHER PHYSICIAN ID SUBMITTED IS NOT A VALID INDIANA LICENSE NUMBER.
1022	SECOND OTHER PHYSICIAN ID NUMBER NOT ON FILE	1022	THE SECOND OTHER PHYSICIAN ID NUMBER SUBMITTED IS NOT A VALID INDIANA LICENSE N
1023	LEVEL OF CARE BILLED NOT ON FILE FOR THIS PROVIDER	1023	PROVIDER NOT ELIGIBLE TO BILL THIS LEVEL OF CARE
1024	BILLING PROVIDER NOT LISITED AS RECIPIENT LTC PROV	1024	BILLING PROVIDER IS NOT RECIPIENT'S LISTED LONG TERM CARE PROVIDER. PLEASE VER

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
1025	BILLING PROVIDER NOT ELIGIBLE TO BILL ON THIS PROG	1025	BILLING PROVIDER NOT ENROLLED IN THE PROGRAM BILLED.
1026	PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE	1026	PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE. PLEASE VERIFY NUMBER AND RES
1027	REFERRING PHYSICIAN NOT ON FILE	1027	REFERRING PHYSICIAN NUMBER NOT ON FILE. PLEASE VERIFY NUMBER AND RESUBMIT
1028	RENDERING PROVIDER SPECIALTY NOT ELIGIBLE TO RENDE	1028	MODIFIER BILLED NOT PAYABLE FOR THIS PROVIDER'S SPECIALTY. PLEASE VERIFY MODIF
1029	PRESCRIBING PROV NOT ELIG TO PRESCRIBE THIS NDC	1029	PRESCRIBING PROVIDER NOT ELIGIBLE TO PRESCRIBE THIS NDC.
1030	ANCILLARY SERVICE NOT COVERED	1030	ANCILLARY SERVICES NOT COVERED.
1031	HIGH RISK PRENATAL CARE MAY ONLY BE RENDERED BY A	1031	HIGH RISK PRENATAL CARE MAY ONLY BE RENDERED BY A PHYSICIAN.
1032	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLAIM T	1032	BILLING PROVIDER IS NOT ELIGIBLE TO BILL THIS CLAIM TYPE.
1033	RENDERING PROVIDER ELIGIBLE WITHOUT SPECIALTY	1033	PROVIDER DOES NOT HAVE A SPECIALTY AREA IDENTIFIED FOR THE DATES OF SERVICE. P
1034	AIM PROVIDER EQUALS IMMIS PROVIDER	1034	PLEASE VERIFY PROVIDER NUMBER AND RESUBMIT.
1035	HOSPICE PROVIDER BILLING FOR HOSPICE SERVICES	1035	BILLING PROVIDER IS NOT RECIPIENT'S LISTED HOSPICE PROVIDER. PLEASE VERIFY PRO
1036	RENDERING PROVIDER NOT ELIGIBLE	1036	RENDERING PROVIDER NOT ELIGIBLE TO BILL ON HCFA CLAIM TYPE
1037	PRIVATE DUTY NURSING	1037	PRIVATE DUTY NURSING IS NOT COVERED IN PACKAGE C.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
1039	SERVICE RENDERED BY OUT OF NETWORK PROVIDER	1039	SERVICE PROVIDED BY AN OUT-OF-NETWORK PROVIDER
1040	MRO SERVICES CAN ONLY BE BILLED ON A HCFA 1500 BY	1040	MRO SERVICES CAN ONLY BE BILLED ON A HCFA 1500 BY A CMHC
1041	BILLING PROV NOT ELIGIBLE FOR RECIP WAIVER PGM	1041	BILLING PROVIDER NOT ELIGIBLE FOR RECIPIENT'S SPECIFIC WAIVER PROGRAM FOR DATES
1996	IMMIS RENDERING PROVIDER ID NUMBER NOT ENROLLED	1996	THE RENDERING PROVIDER HAS NOT BEEN ENROLLED WITHIN THE INDIANA HEALTH COVERAGE
1997	RENDERING PROVIDER ID SUBMITTED UNDER OLD FORMAT	1997	THIS CLAIM WAS BILLED WITH A RENDERING PROVIDER NUMBER FROM THE PREVIOUS MEDICA
1998	IMMIS BILLING PROVIDER ID NUMBER NOT ENROLLED	1998	THE BILLING PROVIDER HAS NOT BEEN ENROLLED WITHIN THE INDIANA HEALTH COVERAGE P
1999	BILLING PROVIDER ID SUBMITTED UNDER OLD FORMAT	1999	THISK CLAIM WAS BILLED WITH A BILLING PROVIDER NUMBER FROM THE PREVIOUS INDIANA
2000	INVALID SEX	2000	THE SEX OF THE RECIPIENT IS NOT ON FILE. PLEASE CONTACT THE COUNTY CASEWORKER
2001	RECIPIENT NUMBER NOT ON FILE	2001	RECIPIENT NUMBER NOT ON FILE. PLEASE VERIFY NUMBER AND RESUBMIT.
2002	RECIPIENT NOT ELIGIBLE FOR MEDICAL ASSISTANCE ON D	2002	DISPENSED DATE PRIOR TO INDIANA HEALTH COVERAGE PROGRAMS ELIGIBILITY DATE

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
2003	RECIPIENT INELIGIBLE ON DATE(S) OF SERVICE	2003	RECIPIENT NOT ELIGIBLE FOR INDIANA HEALTH COVERAGE PROGRAM BENEFITS
2004	RECIPIENT INELIGIBLE FOR THE DATES OF SERVICE	2004	RECIPIENT NOT ELIGIBLE FOR INDIANA HEALTH COVERAGE PROGRAM BENEFITS FOR DATES
2005	SOBRA PREGNANT WOMEN (DETAIL)	2005	THIS SERVICE IS NOT PAYABLE FOR SOBRA RECIPIENTS WITH THE INDICATED DIAGNOSIS.
2006	ALIEN ELIGIBLE FOR MEDICAL EMERGENCY ONLY	2006	ALIEN ELIGIBLE FOR MEDICAL EMERGENCY ONLY
2007	QMB RECIPIENT- BILL MEDICARE FIRST.	2007	QUALIFIED MEDICARE BENEFICIARY (QMB) RECIPIENT-PLEASE BILL MEDICARE FIRST.
2008	RECIPIENT INELIGIBLE FOR LEVEL OF CARE BILLED	2008	RECIPIENT NOT ELIGIBLE FOR THIS LEVEL OF CARE FOR DATES OF SERVICE.
2009	RECIPIENT INELIGIBLE ON DATE(S) OF SERVICE	2009	RECIPIENT NOT ELIGIBLE FOR INDIANA HEALTH COVERAGE PROGRAM BENEFITS FOR DATES O
2010	ALIEN ELIGIBLE FOR MEDICAL EMERGENCY ONLY.	2010	ALIEN ELIGIBLE FOR MEDICAL EMERGENCY ONLY.
2011	RESERVED FOR FUTURE USE	2011	RESERVED FOR FUTURE USE.
2012	PREGNANT AND URGENT CARE ONLY	2012	THIS SERVICE IS NOT PAYABLE FOR PREGNANT & URGENT CARE RECIPIENTS WITH THE IND
2013	RECIPIENT INELIGIBLE FOR LEVEL OF CARE	2013	RECIPIENT NOT ELIGIBLE FOR THIS LEVEL OF CARE FOR DATES OF SERVICE.
2014	NURSING HOME LIABILITY SUBMITTED DIFFERS FROM PATI	2014	PERSONAL RESOURCES COLLECTED DOES NOT AGREE WITH AMOUNT REPORTED BY COUNTY OFFI
2015	INVALID ADMIT AGE	2015	THE RECIPIENT'S AGE IS INVALID FOR THE ADMIT

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			DATE-PLEASE VERIFY AND RESUBMIT.
2016	INVALID DISCHARGE AGE	2016	THE RECIPIENT'S AGE IS INVALID FOR THE DISCHARGE DATE-PLEASE VERIFY AND RESUBMI
2017	RECIPIENT INELIGIBLE ON DATE(S) OF SERVICE DUE TO	2017	THE RECIPIENT IS ENROLLED IN THE RISK BASED MANAGED CARE PORTION OF THE HOOSIER
2018	RECIPIENT INELIGIBLE ON DATE(S) OF SERVICE DUE TO	2018	THE RECIPIENT IS ENROLLED IN THE RISK BASED MANAGED CARE PORTION OF THE HOOSIER
2019	RECIPIENTS ELIGIBLE IN THE SLMB AND QDWI AID CATEG	2019	RECIPIENT IS NOT ELIGIBLE FOR INDIANA HEALTH COVERAGE PROGRAM BENEFITS.
2020	PAS NOT ON FILE	2020	NO DATA ON PAS FILE FOR DIAGNOSIS OR CONDITION BILLED.
2021	PAS ZERO ALLOWED DAYS	2021	ALLOWED DAYS ON THE PAS FILE FOR THE SERVICE BILLED IS 0.
2022	RECIPIENT NOT ENROLLED WITH MCO ON DATE OF SERVICE	2022	RECIPIENT NOT ENROLLED WITH BILLING MANAGED CARE ORGANIZATION.
2023	RECIPIENT INELGIBLE ON DATE(S) OF SERVICE ...	2023	THE RECIPIENT IS ENROLLED IN THE HOOSIER HEALTHWISE FOR PERSONS WITH DISABILITI
2024	RECIPIENT INELIGIBLE FOR HOSPICE LEVEL OF CARE	2024	RECIPIENT NOT ELIGIBLE FOR THIS HOSPICE LEVEL OF CARE FOR THE DATES OF SERVICE.
2025	HOSPICE RECIPIENT BILLED WITHOUT HOSPICE SERVICES	2025	HOSPICE RECIPIENT BILLING FOR NON-HOSPICE SERVICES.
2026	HOSPICE RECIPIENT INELIGIBLE FOR NURSING HOME LEVE	2026	RECIPIENT NOT ELIGIBLE FOR THIS LEVEL OF CARE FOR THE DATES OF SERVICE AND REVE
2027	HOSPICE SERVICES NOT BILLED CORRECTLY	2027	HOSPICE RECIPIENT BEING BILLED FOR NON-HOSPICE SERVICES.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
2028	PATIENT LIABILITY FOR RECIP/REV CODE COMBINATION	2014	PERSONAL RESOURCES COLLECTED DOES NOT AGREE WITH AMOUNT REPORTED BY COUNTY OFFI
2030	RECIPIENT NOT ELIGIBLE IN QI/SLMB/QDWI	2019	RECIPIENT IS NOT ELIGIBLE FOR INDIANA HEALTH COVERAGE PROGRAM BENEFITS.
2031	ONLY FREESTANDING/DPU PROVS CAN BILL LEAVE DAYS	2031	ONLY FREESTANDING AND DPU FACILITIES ARE ALLOWED TO BILL LEAVE DAYS ON INPATIEN
2032	THERA & HOSP ARE ONLY LEAVE DAYS VALID ON PSYCH	2032	ONLY THERAPEUTIC AND HOSPITAL LEAVE DAYS MAY BE BILLED ON INPATIENT PSYCHIATRIC
2033	PACKAGE C RECIPIENTS NOT ELIGIBLE FOR CLAIM TYPE	2033	PACKAGE C RECIPIENTS NOT ELIGIBLE FOR CLAIM TYPE
2035	PKG C/590 RECIP NOT ELIGIBLE FOR WAIVER SERVICES	2035	PKG C/590 RECIPIENT NOT ELIGIBLE FOR WAIVER SERVICES
2202	RECIPIENT NOT ENROLLED WITH BILLING MCO	2022	RECIPIENT NOT ENROLLED WITH BILLING MANAGED CARE ORGANIZATION.
2500	RECIPIENT COVERED BY MEDICARE A (NO ATTACHMENT)	2500	THIS RECIPIENT IS COVERED BY MEDICARE PART A; THEREFORE, YOU MUST FIRST FILE CL
2501	RECIPIENT COVERED BY MEDICARE (WITH ATTACHMENT)	2501	THIS RECIPIENT IS COVERED BY MEDICARE PART A; THEREFORE, YOU MUST FIRST FILE CL
2502	RECIPIENT COVERED BY MEDICARE B (NO ATTACHMENT)	2502	THIS RECIPIENT IS COVERED BY MEDICARE PART B; THEREFORE, YOU MUST FIRST FILE CL
2503	RECIPIENT COVERED BY MEDICARE B (W/ ATTACHMENT)	2503	THIS RECIPIENT IS COVERED BY MEDICARE PART B; THEREFORE, YOU MUST FIRST FILE CL
2504	RECIPIENT COVERED BY PRIVATE INSURANCE(NO ATTACHME	2504	THIS RECIPIENT IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			ME
2505	RECIPIENT COVERED BY PRIVATE INSURANCE(W/ ATTACHMT	2505	THIS RECIPIENT IS COVERED BY PRIVATE INSURANCE WHICH MUST BE BILLED PRIOR TO ME
2999	CLAIM BILLED WITH INACTIVE RID	2999	THIS CLAIM HAS BEEN BILLED WITH A RECIPIENT IDENTIFICATION NUMBER WHICH IS NO L
3000	UNITS EXCEED PA MASTER	3000	PAYMENT HAS BEEN CUTBACK TO THE NUMBER OF UNITS AUTHORIZED ON PA.
3001	DATES OF SERVICE NOT ON PA DATABASE	3001	DATES OF SERVICE NOT ON THE P.A. MASTER FILE.
3002	NDC REQUIRES PRIOR AUTHORIZATION - NOT FOUND	3002	NDC REQUIRES PRIOR AUTHORIZATION, NO APPROVED PA ON FILE.
3003	PROCEDURE CODE REQUIRES PA	3003	PROCEDURE CODE REQUIRES PRIOR AUTHORIZATION, NO APPROVED PA ON FILE.
3004	CLAIM SPANS MULTIPLE SPENDDOWN PERIODS-AND NOT MET	3004	THIS CLAIM COVERS MULTIPLE MONTHS AND SPENDDOWN HAS NOT BEEN MET FOR ALL MONTHS
3005	CLAIM SPANS MULTIPLE SPENDDOWN PERIODS AND NOT MET	3005	THIS CLAIM COVERS MULTIPLE MONTHS AND SPENDDOWN HAS NOT BEEN MET FOR ALL MONTHS
3006	P.A. DOLLARS EXHAUSTED	3006	CLAIM DENIED. APPROVED DOLLAR AMOUNT ON PA EXHAUSTED BY PREVIOUS CLAIM(S).
3007	NO PRIOR AUTHORIZATION SEGMENT FOR LEVEL OF CARE	3007	NO PRIOR AUTHORIZATION SEGMENT ON FILE FOR THE LEVEL OF CARE.
3008	PRIOR AUTHORIZED UNITS EQUAL ZERO	3008	THERE ARE NO UNITS PRIOR AUTHORIZED ON

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			FILE FOR LEVEL OF CARE.
3009	QMB ALSO - CLAIMS SPANS MULTIPLE PERIODS	3009	THIS SERVICE IS NOT PAYABLE, RECIPIENT IS QMB ALSO AND SPENDDOWN HAS NOT BEEN M
3010	OUT OF STATE PROVIDER REQUIRES PRIOR AUTHORIZATION	3010	NON-EMERGENCY OUT OF STATE SERVICES REQUIRE PRIOR AUTHORIZATION.
3011	OUT OF STATE PROVIDER REQUIRES PRIOR AUTHORIZATION	3011	NON EMERGENCY OUT-OF-STATE SERVICES REQUIRE PRIOR AUTHORIZATION.
3012	TRANSPORTATION EXCEEDING FIFTY MILES REQUIRES PA	3012	TRANSPORTATION EXCEEDING FIFTY MILES REQUIRES PA
3013	RESERVED FOR FUTURE USE	3013	DATES OF SERVICE NOT ON P.A. MASTER FILE
3014	SUBSTANCE ABUSE DRG REQUIRES PA	3001	DATES OF SERVICE NOT ON THE P.A. MASTER FILE.
3015	OUT OF STATE NONCOVERED SERVICES - LTC	3015	LONG TERM CARE SERVICES PROVIDED OUTSIDE OF INDIANA ARE NON COVERED SERVICES.
3016	OUT OF STATE HOME HEALTH SERVICES ARE NON COVERED	3016	HOME HEALTH SERVICES PROVIDED OUTSIDE OF INDIANA ARE NON COVERED SERVICES.
4000	MORE THAN TWO SURGICAL UNITS ON THE CLAIM	4000	MORE THAN TWO SURGICAL UNITS ON THE CLAIM.
4001	NON-ANESTHESIOLOGIST CANNOT BILL FOR MEDICAL DIREC	4001	A NON-ANESTHESIOLOGIST MAY NOT BILL MEDICAL DIRECTION,
4002	NDC/HRI/UPC INDICATES A NON-REIMBURSABLE ITEM ON D	4002	NDC/HRI/UPC INDICATES A NON-REIMBURSABLE ITEM ON DATE OF SERVICE
4003	LESS THAN EFFECTIVE DRUG	4003	LESS THAN EFFECTIVE DRUGS ARE NOT COVERED UNDER INDIANA HEALTH COVERAGE PROGRAM

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
4004	NDC NOT ON FILE	4004	THIS NDC IS NOT ON FILE. PLEASE VERIFY THAT THE NDC WAS FILED CORRECTLY. IF T
4005	SUBMITTED CHARGE MORE THAN 5 TIMES THE ALLOWED RAT	4005	THE SUBMITTED CHARGE IS MORE THAN FIVE (5) TIMES THE ALLOWED RATE.
4006	ALLOWED RATE MORE THAN 5 TIMES THE SUBMITTED CHG	4006	PAID AS BILLED.
4006	ALLOWED RATE MORE THAN 5 TIMES THE SUBMITTED CHG	9999	PAID AS BILLED
4007	NONCOVERED NDC DUE TO HCFA TERMINATION	4007	NDC NOT COVERED FOR DATE OF SERVICE.
4008	INVALID DIAGNOSIS FOR PROCEDURE CODE/MODIFIER COMB	4008	DIAGNOSIS CODE INDICATING POSITIVE OR NEGATIVE RESULTS OF TEST DONE FOR HEALTHW
4009	DRUG CHARGE 500% LESS THAN ALLOWED CHG	4009	NON-LEGEND DRUG CHARGE 500% LESS THAN ALLOWED
4009	DRUG CHARGE 500% LESS THAN ALLOWED CHG	9999	PAID AS BILLED
4010	MODIFIER REQUIRES MEDICAL REVIEW	4010	THE DOCUMENTATION SUBMITTED DOES NOT SUPPORT THIS BILLING.
4010	MODIFIER REQUIRES MEDICAL REVIEW	9011	SUPPORTING DOCUMENTATION IS NEEDED FOR THE MODIFIER(S) SUBMITTED ON THIS CLAIM.
4011	INVALID MODIFIER/MODIFIER COMBINATION	4011	INVALID MODIFIER COMBINATION.
4012	ABORTION DIAGNOSIS/PROCEDURE INDICATED	4012	CLAIM DENIED FOR ADDITIONAL INFORMATION. IF THE ABORTION WAS PERFORMED FOR THE
4013	PROCEDURE CODE IS NOT COVERED FOR DATE OF SERVICE	4013	THIS PROCEDURE CODE IS NOT COVERED FOR THIS DATE OF SERVICE.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
4014	NO PRICING SEGMENT ON FILE	4014	CLAIM BEING REVIEWED FOR PRICING..
4014	NO PRICING SEGMENT ON FILE	8327	BILLING AND/OR RENDERING PROVIDER NUMBER NOT VALID FOR WAIVER SERVICES BILLED.
4015	PASARR ASSESSMENTS	4015	THIS CLAIM SHOULD BE SUBMITTED TO IFSSA'S LEVEL OF CARE UNIT. PLEASE VERIFY A
4016	MILES PER TRIP EQUAL TO ZERO	4016	CLAIM DENIED AS MILES PER TRIP EQUAL TO ZERO.
4017	WAITING TIME NOT PAYABLE W/LESS THAN 50 MILES	4017	WAITING TIME IS NOT PAYABLE W/LESS THAN 50 MILES
4018	PROCEDURE/MODIFIER REQUIRES SECONDARY DIAGNOSIS	4018	A SECONDARY DIAGNOSIS CODE IS REQUIRED TO INDICATE REFERRED CONDITION WHEN BILL
4019	PROCEDURE CODE REQUIRES ATTACHMENT	4019	ATTACHMENT REQUIRED FOR SERVICE RENDERED. PLEASE VERIFY AND RESUBMIT.
4020	UNITS BILLED EXCEED ALLOWABLE UNITS FOR PROCEDURE	4020	UNITS BILLED EXCEED ALLOWABLE UNITS FOR THIS PROCEDURE CODE.
4021	PROCEDURE CODE VS PROGRAM INDICATOR	4021	PROCEDURE CODE IS NOT COVERED FOR THE DATES OF SERVICE FOR THE PROGRAM BILLED.
4022	ABORTION DIAGNOSIS/PROCEDURE INDICATED	4022	CLAIM DENIED FOR ADDITIONAL INFORMATION. IF THE ABORTION WAS PERFORMED FOR THE
4023	NDC VS SEX RESTRICTION	4023	NDC CODE NOT COMPATIBLE WITH RECIPIENT'S SEX. PLEASE VERIFY AND RESUBMIT.
4024	MAXIMUM NUMBER OF REFILLS HAS BEEN REACHED	4024	MAXIMUM NUMBER OF REFILLS HAS BEEN REACHED. PLEASE VERIFY AND RESUBMIT.
4025	NDC VS AGE RESTRICTION	4025	NDC VS AGE RESTRICTION, NDC IS INAPPROPRIATE TO BE USED DUE TO RECIPIENTS

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			AGE.
4026	NDC VS DAYS SUPPLY	4026	NDC / DAYS SUPPLY LIMITATIONS. THIS NDC CODE BILLED MAY NOT BE GREATER THAN T
4027	DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE	4027	THE DIAGNOSIS CODE IS INVALID OR NO LONGER EFFECTIVE FOR DATES OF SERVICE. PL
4028	DIAGNOSIS / SEX RESTRICTION (HCFA 1500)	4028	DIAGNOSIS CODE NOT COMPATIBLE WITH RECIPIENT'S SEX. PLEASE VERIFY AND RESUBM
4029	DIAGNOSIS CODE/PLACE OF SERVICE RESTRICTION	4029	DIAGNOSIS CODE VS. PLACE OF SERVICE RESTRICTION. DIAGNOSIS CODE IS INVALID PLA
4030	DIAGNOSIS VS AGE RESTRICTION	4030	THE DIAGNOSIS GIVEN IS NOT COMPATIBLE WITH THE RECIPIENT'S AGE. PLEASE VERIFY
4031	DIAGNOSIS VS SEX RESTRICTION	4031	DIAGNOSIS GIVEN NOT COMPATIBLE WITH RECIPIENT'S SEX. PLEASE VERIFY AND RESUBM
4032	PROCEDURE CODE NOT ON FILE	4032	THE PROCEDURE CODE BILLED IS NOT A VALID PROCEDURE CODE. PLEASE VERIFY AND
4033	INVALID PROCEDURE CODE MODIFIER COMBINATION	4033	THE MODIFIER USED IS NOT COMPATIBLE WITH THE PROCEDURE CODE BILLED. PLEASE VER
4034	PROCEDURE CODE VS AGE RESTRICTION	4034	PROCEDURE CODE BILLED NOT COMPATIBLE WITH RECIPIENT'S AGE. PLEASE VERIFY AND R
4035	PROCEDURE CODE VS SEX RESTRICTION	4035	PROCEDURE CODE BILLED NOT COMPATIBLE WITH RECIPIENT'S SEX. PLEASE VERIFY AND R
4036	PROCEDURE CODE VS PLACE OF SERVICE RESTRICTION	4036	THIS PROCEDURE IS NOT PAYABLE WHEN PERFORMED IN THIS PLACE OF SERVICE. PLEASE
4037	PROCEDURE CODE VS DIAGNOSIS RESTRICTION	4037	THIS PROCEDURE IS NOT CONSISTENT WITH THE DIAGNOSIS BILLED. PLEASE VERIFY AND

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
4038	PREOP DOPPLER STUDIES PAYABLE TO PODIATRIST ONLY W	4038	THIS SERVICE CANNOT BE PAID WITH THE DIAGNOSIS INDICATED. PLEASE VERIFY AND RES
4039	DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS	4039	THE DIAGNOSIS SUBMITTED AS PRINCIPAL DIAGNOSIS IS NOT VALID AS A PRINCIPAL DIAG
4040	PRIMARY DIAGNOSIS CODE NOT ON FILE	4040	THE PRIMARY DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND
4041	SECONDARY DIAGNOSIS CODE NOT ON FILE	4041	THE SECONDARY DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND
4042	THIRD DIAGNOSIS CODE NOT ON FILE	4042	THE THIRD DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND RESU
4043	FOURTH DIAGNOSIS CODE NOT ON FILE	4043	THE FOURTH DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND RE
4044	DIAGNOSIS VS PLACE OF SERVICE MISMATCH	4044	TREATMENT FOR THIS DIAGNOSIS IS NOT COVERED WHEN PERFORMED IN THE PLACE OF SERV
4045	DIAGNOSIS CODE NOT COVERED FOR THIS DATE OF SVS	4045	THE DIAGNOSIS CODE IS INVALID OR NO LONGER EFFECTIVE FOR THE DATES OF SERVICE .
4046	PROCEDURE CODE BILLED PRIOR TO THE PROCEDURE EFF D	4046	THIS DATE OF SERVICE IS PRIOR TO THE PROCEDURE CODE EFFECTIVE. PLEASE VERIFY A
4047	FIFTH DIAGNOSIS CODE NOT ON FILE	4047	THE FIFTH DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND RES
4048	SIXTH DIAGNOSIS CODE NOT ON FILE	4048	THE SIXTH DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND RESU
4049	SEVENTH DIAGNOSIS CODE NOT ON FILE	4049	THE SEVENTH DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND RES

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
4050	EIGHTH DIAGNOSIS CODE NOT ON FILE.	4050	THE EIGHTH DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND R
4051	NINTH DIAGNOSIS CODE NOT ON FILE	4051	THE NINTH DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND RESUB
4052	ADMITTING DIAGNOSIS CODE NOT ON FILE	4052	THE ADMITTING DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS CODE. PLEASE VERIFY AND R
4053	PRINCIPAL PROCEDURE CODE NOT ON FILE	4053	THE PRINCIPAL PROCEDURE CODE BILLED IS NOT A VALID ICD-9-CM PROCEDURE CODE. PL
4054	FIRST OTHER PROCEDURE CODE NOT ON FILE	4054	THE FIRST OTHER PROCEDURE CODE BILLED IS NOT A VALID ICD-9-CM PROCEDURE CODE.
4055	SECOND OTHER PROCEDURE CODE NOT ON FILE	4055	THE SECOND OTHER PROCEDURE CODE BILLED IS NOT A VALID ICD-9-CM PROCEDURE CODE.
4056	THIRD OTHER PROCEDURE CODE NOT ON FILE	4056	THE THIRD OTHER PROCEDURE CODE BILLED IS NOT A VALID ICD-9-CM PROCEDURE CODE.
4057	FOURTH OTHER PROCEDURE CODE NOT ON FILE	4057	THE FOURTH OTHER PROCEDURE CODE BILLED IS NOT A VALID ICD-9-CM PROCEDURE CODE.
4058	FIFTH OTHER PROCEDURE CODE NOT ON FILE	4057	THE FOURTH OTHER PROCEDURE CODE BILLED IS NOT A VALID ICD-9-CM PROCEDURE CODE.
4059	REVENUE CODE NOT ON FILE	4059	THE REVENUE CODE BILLED IS NOT A VALID REVENUE CODE. PLEASE VERIFY AND RESUBMI
4060	E-CODE NOT ON FILE	4060	THE E-CODE BILLED IS NOT A VALID ICD-9-CM CODE. PLEASE VERIFY AND RESUBMIT.
4061	QMB ALSO CLAIMS SPANS MULTIPLE PERIODS	4061	THIS SERVICE IS NOT PAYABLE, RECIPIENT IS QMB ALSO AND SPENDDOWN HAS NOT BEEN M
4061	QMB ALSO CLAIMS SPANS MULTIPLE PERIODS	8330	THIS SERVICE NOT PAYABLE, RECIPIENT IS QMB

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			ALSO AND SPENDDOWN HAS NOT BEEN MET
4062	ORGAN TRANSPLANTS ARE NON-COVERED FOR PACKAGE C	4062	ORGAN TRANSPLANTS ARE NON-COVERED FOR PACKAGE C. PLEASE VERIFY AND RESUBMIT.
4063	ICD-9-CM PROCEDURE CODE/AGE RESTRICTION	4063	THE ICD-9-CM PROCEDURE CODE IS NOT COMPATIBLE WITH THE RECIPIENT'S AGE. PLEASE
4064	ICD-9-CM PROCEDURE/SEX RESTRICTION	4064	ICD-9-CM PROCEDURE CODE GIVEN NOT COMPATIBLE WITH RECIPIENT'S SEX. PLEASE VE
4065	ICD-9-CM PROCEDURE CODE REQUIRES ATTACHMENT	4065	ICD-9-CM PROCEDURE CODE BILLED REQUIRES AN ATTACHMENT. PLEASE VERIFY AND RESUBM
4066	ICD-9-CM PROCEDURE CODE/DIAGNOSIS RESTRICTION	4066	THIS ICD-9-CM PROCEDURE CODE IS NOT PAYABLE WHEN USED TO TREAT THE DIAGNOSIS IN
4067	NON-COVERED ICD-9-CM PROCEDURE CODE	4067	ICD-9-CM PROCEDURE CODE IS NONCOVERED. PLEASE VERIFY AND RESUBMIT.
4068	MILEAGE AND OTHER SERVICES WILL ONLY BE PAID WHEN	4068	MILEAGE AND OTHER SERVICES WILL ONLY BE PAID WHEN BILLED WITH A PAID BASE RATE
4069	NO MILEAGE FOR MULTIPLE PASSENGER BASE RATE	4069	MILEAGE NOT PAYABLE FOR MULTIPLE PASSENGER WHEN BASE RATE IS NOT PRESENT.
4070	SELECT RADIOLOGICAL PROCEDURES BILLED BY A CHIROPR	4070	LOCALIZED SPINE SERIES XRAYS OR XRAYS OF THE JOINTS OR EXTREMITIES ARE REIMBURS
4071	LAB SERVICES BILLED BY CHIROPRACTOR REQUIRE REVIEW	4071	LABORATORY SERVICES ARE REIMBURSABLE ONLY WHEN THE SERVICE IS NECESSITATED BY A
4073	HYSTERECTOMY REQUIRES MANUAL REVIEW	4073	CERTIFICATION THAT HYSTERECTOMY WAS PERFORMED UNDER A LIFE THREATENING

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			EMERGENC
4074	STERILIZATION FOR RECIPIENT LESS THAN AGE 21	4074	INDIANA HEALTH COVERAGE PROGRAM REIMBURSEMENT IS NOT AVAILABLE FOR STERILIZATIO
4075	STERILIZATION REQUIRES MANUAL REVIEW	4075	CLAIM DENIED. PLEASE RESUBMIT WITH A VALID STERILIZATION CONSENT FORM.
4076	DIAGNOSIS NOT COVERED FOR DATES OF SERVICE	4076	TREATMENT FOR THIS DIAGNOSIS CODE IS NOT A COVERED BENEFIT FOR THE DATE OF SERV
4077	NON COVERED REVENUE CODE	4077	THE REVENUE CODE BILLED IS NOT COVERED.
4078	30 MINUTES OF WAITING TIME NOT REIMBURSABLE	4078	30 MINUTES OF WAITING TIME IS NOT REIMBURSABLE.
4079	WAITING TIME REIMBURSABLE ONLY WHEN RECIPIENT IS T	4079	WAITING TIME IS NOT REIMBURSABLE UNLESS THE RECIPIENT IS TRANSPORTED 50 MILES O
4080	TEN MILES NOT REIMBURSABLE PER ONE WAY TRIP	4080	MILEAGE IS NOT REIMBURSABLE UNLESS THE RECIPIENT IS TRANSPORTED 11 MILES OR MOR
4081	INVALID SERVICE - PER DIEM	4081	THE MAXIMUM ALLOWABLE PER DIEM HAS BEEN PAID. ANCILLARIES ARE INCLUDED IN THE
4082	BED RESERVATIONS IN PSYCHIATRIC HOSPITAL	4082	BED RESERVATIONS IN AN INSTITUTION FOR MENTAL HEALTH DISEASE IS A NON-COVERED S
4083	INPATIENT MENTAL HEALTH FACILITIES	4083	INPATIENT CARE RENDERED IN AN INSTITUTION FOR MENTAL HEALTH DISEASE IS NOT COVE
4084	DRUG CHARGE 500% MORE THAN ALLOWED CHARGE	4084	SUBMITTED CHARGE EXCEEDS ALLOWED AMOUNT-PLEASE VERIFY AND RESUBMIT.
4085	INPATIENT CARE/PSYCH HOSP FOR RECIPIENTS 22-64	4085	INPATIENT CARE RENDERED IN AN INSTITUTION FOR MENTAL HEALTH DISEASES IS A MEDIC

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
4086	THERAPIES AFTER MORE THAN 30 DAYS FROM HOSPITAL DI	4086	RESERVED FOR FUTURE USE.
4087	ASC CODE 'G' (INPATIENT PROCEDURE)	4087	INVALID OUTPATIENT SERVICE BILLED-THIS TYPE OF PROCEDURE CAN ONLY BE BILLED AS
4088	ASC CODE "9"	4088	INVALID OUTPATIENT SERVICE BILLED-THIS TYPE OF PROCEDURE CAN ONLY BE BILLED AS
4089	MISSING OR INVALID HCPCS CODE FOR SURGERY REV CODE	4089	MISSING OR INVALID SURGERY CODE-PLEASE VERIFY TO SEE IF HCPC CODE CAN BE BILLE
4090	DRUG AND SUPPLY CODES ARE INCLUDED IN TREATMENT R	4090	PAYMENT FOR 250, 251, 252, 257, 259, 27X DRUG AND SUPPLY REVENUE CODE ARE INCLU
4091	ADD-ON SERV WAS BILLED WITHOUT A TREATMENT ROOM OR	4091	THESE ADD ON SERVICES (25X, 27X, 29X, 37X, 38X, 39X, 62X) ARE ONLY PAYABLE WHEN
4092	TAKE HOME DRUGS NEED TO BE BILLED ON A PHARMACY CL	4092	TAKE HOME DRUGS (REVENUE CODE 253) MUST BE BILLED USING A PHARMACY CLAIM FORM W
4093	AMBULATORY SERVICES NEED TO BE BILLED ON MEDICAL C	4093	TRANSPORTATION SERVICES MUST BE FILED ON THE MEDICAL CLAIM FORM USING A NON-HOS
4094	PROFESSIONAL SERVICES NEED TO BE BILLED ON MEDICAL	4094	PROFESSIONAL SERVICES MUST BE BILLED USING A MEDICAL CLAIM FORM USING A NON-HOS
4095	NONSURGICAL SERVICES ARE NOT REIMBURSED INDIVIDUAL	4095	A NON-SURGICAL SERVICE IS NOT REIMBURSED INDIVIDUALLY IF PERFORMED IN CONJUNCTI
4096	MODIFIER 99	4096	CLAIM BEING REVIEWED..
4097	MODIFIER NOT FOUND ON PROCESSING MODIFIER	4097	MODIFIER USED IS NOT A PROCESSING MODIFIER.
4098	RVU NOT ON FILE	4098	PRICING BEING REVIEWED.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
4099	DRG NOT ON FILE	4099	PRICING BEING REVIEWED.
4100	NO BASE AMOUNT ON FILE FOR THE DATES OF SERVICE	4100	PRICING BEING REVIEWED.
4101	NO TRIM POINT FACTOR ON FILE FOR DOS	4101	NO TRIM POINT FACTOR ON FILE FOR DATES OF SERVICE.
4102	NO MARGINAL COST FACTOR FOR DOS	4102	NO MARGINAL COST FACTOR ON FILE FOR DATES OF SERVICE.
4103	DRG WITH ZERO QUANTITY DOES NOT HAVE A LEVEL OF CA	4103	PRICING BEING REVIEWED.
4104	HBO THERAPY RESTRICTED BY DIAGNOSIS CODE	4104	SERVICE DENIED. MEDICAL NECESSITY FOR USE OF HBO HAS NOT BEEN ADEQUATELY DOCUM
4105	NO FLAT FEE ON FILE	4105	PRICING BEING REVIEWED
4106	REV CODE IS NOT AN ACCOMMODATION OR ANCILLARY	4106	REVENUE CODE IS NOT AN ACCOMMODATION OR ANCILLARY.
4107	REVENUE CODE IS NOT APPROPRIATE/COVERED FOR SERVIC	4107	REVENUE CODE IS NOT APPROPRIATE/NOT COVERED FOR THE "TYPE" OF SERVICE BEING PRO
4108	NO ASC ON FILE	4108	PRICING BEING REVIEWED.
4110	NON ANATOMICAL LABORATORY	4110	SERVICE DENIED. THE INTERPRETATION OF NON-ANATOMICAL LABORATORY PROCEDURES, OTH
4111	COST TO CHARGE RATIO NOT FOUND	4111	PRICING BEING REVIEWED.
4112	MAXIMUM NUMBER OF LAB DETAILS ADDED TO THE CLAIM-M	4112	THE MAXIMUM NUMBER OF LABORATORY DETAILS ADDED TO THE CLAIM HAS BEEN OBTAINED.
4113	UNIT DOSE PACKAGING COVERED FOR	4113	UNIT DOSE PACKAGING IS ONLY PAYABLE TO

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
	RESIDENTS OF LONG		NURSING HOME INDICATED RECIPIENTS.
4114	NO GPCI ON FILE	4114	PRICING BEING REVIEWED.
4115	NO RBRVS CONVERSION FACTOR	4115	PRICING BEING REVIEWED.
4116	DIAGNOSIS IS NOT VALID FOR DRG PRICING	4116	THE DIAGNOSIS CODE USED IS NOT VALID FOR THE DIAGNOSIS RELATED GROUP. PLEASE V
4117	OTCS NOT PAYABLE TO PHYSICIANS	4117	OVER THE COUNTER ITEMS MAY BE BILLED BY PHARMACISTS ONLY.
4118	ASC CODE 'N' (NONSPECIFIC,NONCOVERED SERV NOT PAY	4118	NONSPECIFIC, NONCOVERED OUTPATIENT PROCEDURE IS NOT PAYABLE. PLEASE VERIFY AND
4119	REVENUE CODE NOT A CORONARY OR NON CORONARY SERVIC	4119	THE REVENUE CODE BILLED IS NOT A CORONARY OR NON CORONARY SERVICE FOR BLOOD PRO
4120	RESERVED FOR FUTURE USE	4120	VALUE CODE IS MISSING
4122	VALUE CODE MISSING	4122	VALUE CODE MISSING.
4126	OTCS NON-COVERED FOR PACKAGE C RECIPIENTS	4126	OTCS NON-COVERED FOR PACKAGE C RECIPIENTS.
4200	CLAIM PRICED AT ZERO	4200	PRICING BEING REVIEWED.
4201	590 REIMBURSE. PERCENTAGES CALCULATED WITH POLICY	4201	PAYMENT HAS BEEN CALCULATED ACCORDING TO CURRENT INDIANA HEALTH COVERAGE PROGRA
4202	BURN OUTLIERS	4202	PAYMENT HAS BEEN CALCULATED ACCORDING TO CURRENT INDIANA HEALTH COVERAGE PROGRA
4203	DENIAL MODIFIER FOR NON COVERED MRO	4203	THIS SERVICE IS A NON-COVERED INDIANA HEALTH COVERAGE PROGRAM SERVICE AS THE

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
	SERVICES-Y8		RE
4204	INVALID DIAGNOSIS FOR PROCEDURE CODE/MODIFIER COMB	4204	RESERVED FOR FUTURE USE
4205	NO PRICING SEGMENT ON FILE	4205	PRICING BEING REVIEWED.
4206	BILLED PRODUCT QUANTITY (UNITS) > ALLOWED ESTIMATE	4206	THE UNITS BILLED ARE 500% GREATER THAN THE NUMBER OF UNITS ANTICIPATED FOR THE
4207	CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE BILLE	4207	EFFECTIVE CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE BILLED.
4208	INVALID CLIA CERTIFICATION/PROCEDURE CODE COMBINAT	4208	THE PROCEDURE CODE BILLED IS INVALID WITH YOUR CLIA CERTIFICATION ON FILE.
4209	NO PRICING SEGMENT FOR PROCEDURE/MODIFIER COMBINAT	4209	NO MATCHING PRICING SEGMENT FOR THE PROCEDURE/MODIFIER COMBINATION BILLED ON TH
4210	PRICING INDICATOR NOT VALID FOR DENTAL CLAIMS	4210	THE PROCEDURE CODE BILLED IS NOT APPROPRIATE FOR DENTAL CLAIMS. PLEASE RESUBMI
4213	RE-USED CODES	4213	THIS NDC/HRI/UPC CODE SUBMITTED HAS BEEN RE-USED FOR A DIFFERENT PRODUCT, INVA
4214	HOSPICE/WAIVER DUPLICATIVE SERVICES	4212	THIS SERVICE IS COVERED UNDER THE HOSPICE PROGRAM.
4215	REVENUE CODE NOT VALID FOR THIS BILL TYPE	4215	REVENUE CODE NOT VALID FOR THIS BILL TYPE
4216	PROCEDURE CODE NOT ELIGIBLE FOR RECIP WAIVER PGM	4216	PROCEDURE CODE NOT ELIGIBLE FOR RECIPIENT'S WAIVER PROGRAM
4217	WAIVER PROCEDURE CODE REQUIRES WAIVER BILLING PROV	4217	WAIVER PROCEDURE CODE REQUIRES WAIVER BILLING PROVIDER

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Error Status Code	ESC Description	EOB	EOB Description
4218	WAIVER PROC CODE CAN NOT BE BILLED ON CLAIM TYPE	4218	WAIVER PROCEDURE CODE CAN NOT BE BILLED ON THIS CLAIM TYPE
5000	POSSIBLE DUPLICATE	5000	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5001	EXACT DUPLICATE	5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5002	DUPLICATE OF A PREVIOUS ADJUSTMENT	5002	THIS ADJUSTMENT IS A DUPLICATE OF A PREVIOUS ADJUSTMENT.
5003	POSSIBLE POS REVERSAL DUPLICATE	5003	THIS IS A DUPLICATE OF ANOTHER CLAIM REVERSAL.
5004	REVERSAL NOT PROCESSED NO MATCH FOUND	5004	REVERSAL NOT PROCESSED, NO MATCH FOUND ON RX NUMBER AND PROVIDER NUMBER. PLEAS
5006	POS REVERSAL CLAIM OVER 60 DAYS	5006	REVERSAL NOT PROCESSED, CLAIM OVER 60 DAYS - SUBMIT MANUAL ADJUSTMENT.
5007	EXACT DUPLICATE - HEADER	5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5007	EXACT DUPLICATE - HEADER	5007	THIS IS A DUPLICATE OF ANOTHER CLAIM. IF THIS CLAIM WAS INTENDED TO BE AN ADJU
5008	SUSPECT DUPE - HEADER	5000	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5009	SUSPECT DUPE - DIFFERENT PROV/ALLOWED	5000	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5010	EXACT DUPLICATE - TOOTH SURFACE	5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5011	POSSIBLE DUPLICATE - TOOTH SURFACE	5000	THIS IS A DUPLICATE OF ANOTHER CLAIM.
6000	MANUAL PRICING REQUIRED	6000	THE PAYMENT HAS BEEN CALCULATED ACCORDING TO CURRENT INDIANA HEALTH COVERAGE PR
6000	MANUAL PRICING REQUIRED	9008	LINE ITEM SUBMITTED WITH UNCLEAR ITEMIZATION. PLEASE RESUBMIT WITH

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			APPROPRIATE
6001	CMPLT. PROC PAYABLE AT REDUCED RATE	6001	PAYMENT FOR COMPLETE PROCEDURE PAYABLE AT A REDUCED AMOUNT WHEN THE TECHNICAL O
6001	CMPLT. PROC PAYABLE AT REDUCED RATE	9001	INDIANA HEALTH COVERAGE PROGRAM REIMBURSEMENT REDUCED BY THE RECIPIENT'S CO-PAY
6002	CRNA/AA & ANESTHESIOLOGIST SERV SAME PROC REQ REV	6002	REIMBURSEMENT FOR ANESTHESIOLOGIST AND CRNA/AA SERVICES NOT PAYABLE UNLESS MEDI
6003	RESERVED FOR FUTURE USE	6003	RESERVED FOR FUTURE USE
6004	ESTABLISHED INTERMEDIATE OFFICE VISIT (ONE EVERY 3	6004	INTERMEDIATE (E&M) OFFICE VISIT CODE IS LIMITED TO ONE EVERY 30 DAYS.
6005	ESTABLISHED EXTENDED OFFICE VISIT (1 EVERY 60 DAYS	6005	EXTENDED OFFICE VISITS ARE LIMITED TO ONE PER 60 DAYS.
6006	ONLY 1 NEW PATIENT VISIT PER THREE (3) YEARS.	6006	NEW PATIENT VISITS ARE LIMITED TO ONE PER RECIPIENT, PER PROVIDER WITHIN THE LA
6007	LAB SERVICES EXCEEDING $400.00 PER MONTH	6007	INDIANA HEALTH COVERAGE PROGRAM BENEFITS LIMITS REIMBURSEMENT OF LABORATORY SER
6008	CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODE(S	6008	SERVICES INCLUDED IN THE CRITICAL CARE/NEO-NATAL INTENSIVE CARE VISIT CODES ARE
6009	MEDICAL VS MEDICAL OVERLAPS PREVIOUS HOSPITAL CARE	6009	PAYMENT FOR IN-HOSPITAL MEDICAL CARE FOR THIS DATE OF SERVICE HAS BEEN MADE TO
6010	EXCESSIVE PHYS. EXAM/1 PER 12 MO. SAME PROVIDER	6010	THIS RECIPIENT HAS PREVIOUSLY RECEIVED A COMPLETE EXAMINATION WITHIN THE PAST Y

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Error Status Code	ESC Description	EOB	EOB Description
6011	RADIOLOGY/TECHNICAL COMP. FOR RADIOLOGY OR PATHOLO	6011	PROFESSIONAL OR TECHNICAL COMPONENT NOT SEPARATELY REIMBURSABLE WHEN PAYMENT HA
6012	MEDICAL SERVICES 30 PER YEAR	6012	REIMBURSEMENT IS LIMITED TO 30 MEDICAL SERVICES PER RECIPIENT PER 12 MONTHS UNL
6013	MULTIPLE IN-HOSPITAL VISITS SAME DAY/SAME PROVIDER	6013	THE NUMBER OF SERVICE(S) PROVIDED FOR THIS RECIPIENT FOR THIS DATE OF SERVICE E
6014	GLOBAL PAYABLE AT A REDUCED FEE WHEN COMP. PD.	6014	MEDICAL SERVICES PAYABLE AT A REDUCED AMOUNT WHEN RELATED COMPONENTS HAVE BEEN
6015	GLOBAL VS COMPONENTS RESPIRATORY SYSTEM	6015	SURGERY PAYABLE AT REDUCED AMOUNT WHEN RELATED COMPONENTS HAVE BEEN PAID FOR TH
6016	RESERVE FOR FUTURE USE	6016	SERVICE DENIED. PAYMENT HAS BEEN MADE PREVIOUSLY FOR THE EXTRACTION OF THIS TO
6017	GLOBAL ENDOCRINE/NERVOUS/EYE VS COMPONENTS	6017	SERVICE PAYABLE AT REDUCED AMOUNT WHEN RELATED COMPONENTS HAVE BEEN PAID FOR TH
6017	GLOBAL ENDOCRINE/NERVOUS/EYE VS COMPONENTS	9017	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PR
6018	GLOBAL FEE- IMMUNIZATIONS	6018	COMPONENT IMMUNIZATION PROCEDURE CODES NOT REIMBURSABLE WHEN GLOBAL IMMUNIZATIO
6019	INITIAL/ESTABLISHED VISITS NOT PAYABLE SAME DOS AS	6019	INITIAL PATIENT VISITS / ESTABLISHED PATIENT VISITS ARE NOT PAYABLE ON THE SAME
6020	RESERVED FOR FUTURE USE	6020	RESERVED FOR FUTURE USE.

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Error Status Code	ESC Description	EOB	EOB Description
6020	RESERVED FOR FUTURE USE	6022	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PR
6021	RESERVED FOR FUTURE USE	6021	RESERVED FOR FUTURE USE
6022	COMPONENTS NOT PAYABLE WHEN GLOBAL PAID DIGESTIVE	6022	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PR
6023	GLOBAL PAYABLE AT A REDUCED FEE WHEN COMPONENTS PA	6023	SURGERY PAYABLE AT REDUCED AMOUNT WHEN RELATED COMPONENTS HAVE BEEN PAID FOR TH
6024	ELECTRONIC PACEMAKER ANALYSIS TWO (2) EVERY 6 MONT	6024	REIMBURSEMENT FOR ELECTRONIC PACEMAKER ANALYSIS IS LIMITED TO FREQUENCY STIPULA
6025	EXCESSIVE TRANSTELEPHONIC MONITORING OF PACEMAKER	6025	REIMBURSEMENT FOR TRANSTELEPHONIC MONITORING OF PACEMAKER LIMITED TO FREQUENCY
6026	HOLTER MONITORING 1 EVERY 6 MONTHS	6026	REIMBURSEMENT FOR HOLTER MONITORING IS LIMITED TO ONE EVERY SIX MONTHS. MEDICAL
6027	SELECT MED SVS REIMBURSABLE ONLY ONCE PER DAY	6027	REIMBURSEMENT FOR PROCEDURE CODE BILLED IS LIMITED TO ONCE PER DAY. MAXIMUM RE
6028	INITIAL AND PERIODIC VISITS NOT PAYABLE SAME DOS	6028	INITIAL AND ESTABLISHED PREVENTATIVE HEALTH (EPSDT) VISIT ARE NOT REIMBURSABLE
6029	RESERVED FOR FUTURE USE	6029	RESERVED FOR FUTURE USE
6030	CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODES	6030	CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODES ARE PAYABLE AT A REDUCED AMOU
6030	CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODES	9030	CRITICAL CARE/NEONATAL INTENSIVE CARE VISIT CODES NOT PAYABLE WHEN THE AMOUNT

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Error Status Code	ESC Description	EOB	EOB Description
			P
6031	"GLOBAL IMMUNIZATION NOT PAYABLE WHEN COMPONENT PA	6031	"GLOBAL IMMUNIZATION NOT PAYABLE WHEN COMPONENT IMMUNIZATION PROCEDURE CODE HAS
6032	EXTRACTION/SURGICAL PROCEDURES PAYABLE AT REDUCED	6032	EXTRACTIONS/SELECT SURGICAL PROCEDURES PAYABLE AT REDUCED AMOUNT WHEN SUTURING
6033	PROPHYLAXIS LIMITED TO TWO/SIX MOS INSTITUTIONALIZ	6033	REIMBURSEMENT IS LIMITED TO TWO TREATMENTS OF PROPHYLAXIS TO INSTITUTIONALIZED
6034	GLOBAL SURGERY PAYABLE AT REDUCED AMOUNT WHEN COMP	6034	REIMBURSEMENT FOR GLOBAL SURGERY PAYABLE AT A REDUCED AMOUNT WHEN COMPONENTS OF
6035	COMPONENTS OF SURGICAL CARE NOT PAYABLE WHEN GLOBA	6035	SEPARATE REIMBURSEMENT FOR COMPONENTS OF SURGICAL CARE NOT PAYABLE WHEN GLOBAL
6036	ORAL SURGERY PAYABLE AT REDUCED RATE WHEN APICOECT	6036	ORAL SURGERY PAYABLE AT REDUCED AMOUNT WHEN APICOECTOMY HAS BEEN PAID FOR THE S
6036	ORAL SURGERY PAYABLE AT REDUCED RATE WHEN APICOECT	9036	ORAL SURGERY NOT PAYABLE WHEN AMOUNT PAID FOR APICOECTOMY ON SAME DATE OF SERVI
6037	ONE ASSISTANT SURGEON ALLOWED FOR SELECT SURGERIES	6037	ONLY ONE ASSISTANT SURGEON MAY BE PAID FOR THE SURGERY BILLED. PAYMENT HAS ALR
6038	TWO ASSISTANT SURGEONS ALLOWED FOR SELECT SURGERIE	6038	REIMBURSEMENT FOR ASSISTANT SURGEON SERVICES LIMITED TO TWO ASSISTANTS FOR THE

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Error Status Code	ESC Description	EOB	EOB Description
6039	ASSISTANT SURGEON NOT PAYABLE WHEN CO-SURGEON PAID	6039	ASSISTANT SURGEON SERVICES NOT REIMBURSABLE WHEN CO-SURGEON HAS BEEN PAID FOR T
6040	CO-SURGEON PAID AT REDUCED AMT. WHEN ASSISTANT SUR	6040	CO-SURGEONSERVICES ARE NOT REIMBURSABLE WHEN AN ASSISTANT SURGEON HAS ALREADY
6041	E&M CODES NOT REIMBURSABLE WITH PRENATAL CODES	6041	ROUTINE EVALUATION AND MANAGEMENT VISITS ARE NOT REIMBURSABLE WHEN BILLED IN CO
6042	PRENATAL CODES NOT REIMBURSBLE WITH E&M CODES	6042	PRENATAL VISITS ARE NOT REIMBURSABLE WHEN BILLED IN CONJUNCTION WITH ROUTINE EV
6043	PRENATAL VISITS LIMITED TO 14 IN A 10 MO. PERIOD	6043	ANTEPARTUM CARE VISITS LIMITED TO 14 VISITS IN 10 MONTHS UNLESS A MEDICALLY HIG
6044	PRENATAL VISITS LIMITED TO THREE IN SECOND TRIMEST	6044	ONLY THREE PRENATAL VISITS ARE REIMBURSABLE DURING THE SECOND TRIMESTER OF PREG
6045	PRENATAL VISITS LIMITED TO 8	6045	ONLY EIGHT PRENATAL VISITS ARE REIMBURSABLE DURING THE THIRD TRIMESTER OF PREGN
6046	EXCESSIVE HOSPITAL LEAVE DAYS.	6046	SERVICES CUTBACK-EXCEEDS ALLOWABLE LEAVE DAYS UNDER THE INDIANA HEALTH COVERAG
6047	EXCESSIVE THERAPEUTIC LEAVE DAYS	6047	SERVICES CUTBACK- EXCEEDS ALLOWABLE THERAPEUTIC LEAVE DAYS UNDER THE INDIANA H
6048	COMPONENTS NOT PAYABLE WHEN GLOBAL	6048	SEPARATE REIMBURSEMENT IS NOT AVAILABLE

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Error Status Code	ESC Description	EOB	EOB Description
	PAID ENDOCRINE/		FOR COMPONENT ENDOCRINE/NERVOUS/EYE/EAR
6049	COMPONENTS NOT PAYABLE WHEN GLOBAL PAID INTEGUMENT	6049	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT INTEGUMENTARY, NEUROMUSCU
6050	CARE COORDINATOR-REASSESSMENT	6050	REIMBURSEMENT LIMITED TO TWO CARE COORDINATION REASSESSMENTS PER PREGNANCY
6051	CARE COORDINATOR- INITIAL ASSESSMENT	6051	REIMBURSEMENT LIMITED TO 1 CARE COORDINATION INITIAL ASSESSMENT PER PREGNANCY.
6052	CARE COORDINATION POST-PARTUM ASSESSMENT/OUTCOME	6052	REIMBURSEMENT IS LIMITED TO ONE CARE COORDINATION POST PARTUM ASSESSMENT PER PR
6053	HIV/AIDS CASE MANAGEMENT	6053	INDIANA HEALTH COVERAGE PROGRAM BENEFITS LIMIT CASE MANAGEMENT (Z5950) TO 128 U
6054	ONLY ONE HEARING TEST PER 36 MO. WITHOUT PA	6054	AUDIOLOGICAL ASSESSMENTS ARE LIMITED TO ONCE EVERY 3 YEARS PER RECIPIENT. PRIO
6055	RESERVED FOR FUTURE USE.	6055	RESERVED FOR FUTURE USE
6056	ONLY 1 HEARING AID REPAIR PER 12 MO. FOR 18 & >	6056	REIMBURSEMENT FOR HEARING AID REPAIRS FOR RECIPIENTS 18 AND OLDER IS LIMITED TO
6057	HEARING AID REPAIR PER 12 MONTHS RECIPIENT UNDER	6057	REIMBURSEMENT FOR HEARING AID REPAIRS FOR RECIPIENTS LESS THAN 18 YEARS OF AGE
6058	HEARING AID EARMOLDS REPAIR PER 12 MONTHS	6058	REIMBURSEMENT FOR HEARING AID EARMOLD REPAIR FOR RECIPIENTS 18 AND OLDER IS LIM

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Error Status Code	ESC Description	EOB	EOB Description
6059	HEARING AID EARMOLDS REPAIR PER 12 MONTHS-RECIPIEN	6059	REIMBURSEMENT FOR HEARING AID EARMOLD REPAIR FOR RECIPIENTS LESS THAN 18 YEARS
6060	SPEECH THERAPY EVALUATIONS/ONE PER YEAR	6060	REIMBURSEMENT FOR SPEECH EVALUATION IS LIMITED TO ONCE EVERY TWELVE MONTHS. PRI
6061	COMPONENTS NOT PAID WHEN GLOBAL PAID G.U./REPRODUC	6061	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT GENITAL URINARY/REPRODUCT
6062	RESERVED FOR FUTURE USE	6062	RESERVED FOR FUTURE USE.
6063	COMPONENTS NOT PAYABLE WHEN GLOBAL PAID RESPIRATOR	6063	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT RESPIRATORY PROCEDURES WH
6064	COMPONENTS NOT PAYABLE WHEN GLOBAL PAID MEDICAL SY	6064	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT MEDICAL SYSTEM PROCEDURES
6065	DME TOTAL RENTAL AMOUNT NOT TO EXCEED FEE FOR PURC	6065	THIS ITEM HAS BEEN RENTED UP TO THE INDIANA HEALTH COVERAGE PROGRAM MAXIMUM ALL
6066	RESERVE FOR FUTURE USE	6066	RESERVE FOR FUTURE USE
6067	EXCESSIVE THERAPEUTIC LEAVE DAYS(ICF)	6067	EXCEEDS ALLOWABLE THERAPEUTIC LEAVE DAYS FOR INTERMEDIATE CARE FACILITY PATIENT
6068	EXCESS. THERAP. LEAVE DAYS (ICF/MRO OR CRF/DD)	6068	EXCEEDS ALLOWABLE THERAPEUTIC LEAVE DAYS FOR ICF/MR OR CRF/DD PATIENTS UNDER TH
6069	OFFICE VISITS 30 PER YEAR	6069	REIMBURSEMENT IS LIMITED TO 30 OFFICE VISITS FOR PCCM RECIPIENT PER ROLLING 12
6070	PRENATAL VISITS LIMIT TO FOUR IN FIRST	6070	ONLY FOUR PRENATAL VISITS ARE

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Error Status Code	ESC Description	EOB	EOB Description
	TRIMESTER		REIMBURSABLE DURING THE FIRST TRIMESTER OF PREGNA
6071	COMP. NOT PAYABLE WHEN GLOBAL PAID CARDIOVAS/LYMPH	6071	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT CARDIOVASCULAR/LYMPHATIC
6072	GLOBAL PROC VS COMP CARDIOVASCULAR/LYMPHATIC SYS.	6072	SERVICE PAYABLE AT REDUCED AMOUNT WHEN RELATED COMPONENTS HAVE BEEN PAID FOR TH
6073	NO MORE THAN 120 HOURS WITHIN 30 DAYS OF HOSPITAL	6073	NO MORE THAN 120 HOME HEALTH HOURS ALLOWED WITHIN 30 DAYS OF A HOSPITAL DISCHAR
6076	PROTHROMBIN STRIPS & CUVETTES LIMIT 4 EA. /MONTH	6076	REIMBURSEMENT FOR HOME PROTIME REAGENT STRIPS AND CUVETTES ARE LIMITED TO FOUR
6077	SALIVARY ESTRIOL TEST LIMITED TO $425/PREGNANCY	6077	REIMBURSEMENT FOR SALIVARY ESTRIOL LEVEL TESTS LIMITED TO $425.00 PER PREGNANCY
6078	SALIVARY ESTRIOL TEST NOT BILLABLE W/TOCOLYTIC THE	6078	SALIVARY ESTRIOL TESTS AND HOME TOCOLYTIC THERAPY NOT BILLABLE WITHIN SIX (6) M
6079	NCP BUNDLING OF COMPONENTS	6079	THE PROCEDURE CODE BILLED IS A GLOBAL PROCEDURE AND A COMPONENT OF THAT PROCEDU
6080	DME RENTALS LIMITED TO 15 MONTHS	6080	INDIANA HEALTH COVERAGE PROGRAM BENEFITS LIMITS DME RENTAL OF THIS ITEM TO 15 M
6081	DME NOT PAYABLE WHEN PT IN ICF/SNF	6081	RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT (DME) ITEMS ARE NOT PAYABLE WHE
6082	NURSING FACILITY VISITS VS DME SERVICES	6082	RENTAL OR PURCHASE OF DURABLE MEDICAL

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Error Status Code	ESC Description	EOB	EOB Description
			EQUIPMENT (DME) ITEMS ARE NOT PAYABLE WHE
6083	MANUAL PRICING REQUIRED AT THE CLAIM HEADER LEVEL	6083	THE PAYMENT HAS BEEN CALCULATED ACCORDING TO CURRENT INDIANA HEALTH COVERAGE P
6084	RESERVED FOR NCP BUNDLING	6084	THE PROCEDURE CODE BILLED IS A COMPONENT OF A GLOBAL PROCEDURE THAT HAS BEEN PA
6090	OFFICE VISITS LIMITED TO ONE PER YEAR-PODIATRIST	6090	INDIANA MEDICAD BENEFITS ALLOW PAYMENT FOR ONE (1) PODIATRY OFFICE VISIT PER R
6091	ONE INITIAL OFFICE VISIT PER RECIPIENT - PODIATRIS	6091	NEW PATIENT PODIATRY OFFICE VISITS ARE REIMBURSED ONCE PER PROVIDER PER LIFETIM
6100	MAX OF 50 CHIRO. THERAPEUTIC PHY. MEDICINE TREATME	6100	REIMBURSEMENT LIMITED TO FIFTY (50) THERAPEUTIC PHYSICAL MEDICINE TREATMENTS BY
6101	CHIROPRACTIC RESTRICTIVE OFFICE VISITS CODES (NP)	6101	NEW PATIENT CHRIROPRACTICE OFFICE VISITS ARE REIMBURSABLE ONCE PER PROVIDER PER
6102	CHIROPRACTIC OFFICE VISITS LIMITED TO 5 PER YEAR	6102	INDIANA HEATH COVERAGE PROGRAMS REIMBURSEMENT LIMITED TO FIVE CHIROPRACTIC OFFI
6103	COMPONENT SPINAL X-RAYS VS FULL SPINE X-RAY	6103	COMPONENT SPINE X-RAYS ARE NOT REIMBURSABLE FOR CHIROPRACTORS WHEN A FULL SERIE
6104	DME RENTAL FROM CHIROPRACTOR OF MORE THAN 1 MONTH	6104	REIMBURSEMENT TO CHIROPRACTORS FOR RENTAL OF DME IS LIMITED TO ONE PER MONTH OR
6105	ONE FULL SPINE X-RAY PER YEAR FOR	6105	INDIANA HEALTH COVERAGE PROGRAM REIMBURSEMENT IS LIMITED TO ONE (1) FULL

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Error Status Code	ESC Description	EOB	EOB Description
	CHIROPRACTOR		SPINAL
6106	COMPONENT SPINAL X-RAYS GREATER THAN $95.00/YEAR	6106	MAXIMUM REIMBURSEMENT FOR ANY COMBINATION OF SPINAL SERIES XRAY COMPONENTS TO A
6107	FULL SPINE X-RAY PAYABLE AT REDUCED AMOUNT WHEN CO	6107	FULL SERIES SPINAL X-RAY IS PAYABLE AT A REDUCED AMOUNT TO CHIROPRACTORS WHEN C
6108	GLOBAL PAYABLE AT A REDUCED FEE WHEN COMPONENTS PA	6108	RADIOLOGY SERVICES PAYABLE AT REDUCED AMOUNT WHEN RELATED COMPONENTS HAVE BEEN
6109	RESERVED FOR FUTURE USE	6109	RESERVED FOR FUTURE USE
6110	COMP PROC. NOT PAYABLE WHEN GLOBAL PROC. PD - RADI	6110	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PR
6111	CHIROPRACTIC OFFICE VISITS LIMITED TO FIVE PER YEA	6111	REIMBURSEMENT IS LIMITED TO FIVE CHIROPRACTIC OFFICE VISITS PER YEAR PER RECIPI
6112	MAX OF 14-CHIRO THERAPEUTIC PHYS MED TRT PER YR	6112	THERAPEUTIC PHYSICAL MEDICINE TREATMENTS ARE LIMITED TO 14 PER RECIPIENT PER CA
6113	DME LIMITED TO $2,000 PER RECIPIENT PER CALENDAR Y	6113	DURABLE MEDICAL EQUIPMENT IS LIMITED TO $2,000 PER RECIPIENT PER CALENDAR YEAR
6114	DME LIMITED TO $5,000 PER RECIPIENT PER LIFETIME	6114	REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT IS LIMITED TO $5,000 PER RECIPIENT
6115	PHYS THERAPY SERVICES LIMITED TO 50 VISITS PER YR	6115	REIMBURSEMENT IS LIMITED TO 50 PHYSICAL THERAPY TREATMENTS PER RECIPIENT PER CA
6116	SPEECH THERAPY SVCS LIMITED TO 50 VISITS	6116	REIMBURSEMENT IS LIMITED TO 50 SPEECH

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
	PER YEAR		THERAPY TREATMENTS PER RECIPIENT PER CALE
6118	OCCUPATIONAL THERAPY SVCS LIMITED TO 50 VISITS YR	6118	REIMBURSEMENT IS LIMITED TO 50 OCCUPATIONAL THERAPY TREATMENTS PER RECIPIENT PE
6119	INPT REHAB SERVICES LIMITED TO 50 DAYS PER CALENDA	6119	REIMBURSEMENT IS LIMITED TO 50 DAYS OF INPATIENT REHABILITATION SERVICES PER RE
6120	OUTPATIENT MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	6120	REIMBURSEMENT IS LIMITED TO 30 VISITS FOR OUTPATIENT MENTAL HEALTH/SUBSTANCE AB
6121	OUTPATIENT MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	6121	REIMBURSEMENT IS LIMITED TO 50 VISITS MAXIMUM FOR OUTPATIENT MENTAL HEALTH/SUBS
6122	CHIROPRACTIC THERAPEUTIC PHYSICAL MEDICINE TREATME	6122	THERAPEUTIC PHYSICAL MEDICINE TREATMENTS EXCEEDING FOURTEEN (14), UP TO A MAXIM
6124	IMPLANTABLE LOOP RECORDER LIMITED TO ONE(1) EVERY	6124	REPLACEMENT OF IMPLANTABLE LOOP RECORDERS LIMITED TO ONE EVERY 24 MONTHS.
6130	RESERVED FOR FUTURE USE	6130	RESERVED FOR FUTURE USE.
6149	RESERVED FOR FUTURE USE	6900	PSYCHIATRIC SERVICES IN EXCESS OF 20 PER YEAR REQUIRE AN APPROVED PRIOR AUTHORI
6150	CONSULTATION BILLED 15 DAYS BEFORE OR AFTER ANOTHE	6150	THE NUMBER OF CONSULTATIONS PROVIDED FOR THIS RECIPIENT EXCEEDED INDIANA HEALTH
6151	CONSULTATION BILLLED 7 DAYS BEFORE OR AFTER SURGER	6151	RESERVED FOR FUTURE USE
6151	CONSULTATION BILLLED 7 DAYS BEFORE OR AFTER SURGER	6152	SURGERY PAYABLE AT A REDUCED AMOUNT WHEN CONSULTATION PREVIOUSLY PAID AND IS R

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
6152	SURGERY PAYABLE AT REDUCED AMOUNT WHEN CONSULT PAI	6151	RESERVED FOR FUTURE USE
6152	SURGERY PAYABLE AT REDUCED AMOUNT WHEN CONSULT PAI	6152	SURGERY PAYABLE AT A REDUCED AMOUNT WHEN CONSULTATION PREVIOUSLY PAID AND IS R
6156	RESERVED FOR FUTURE USE	6156	RESERVED FOR FUTURE USE
6200	PANORAMIC/FULL MOUTH VS. BITEWINGS	6200	REIMBURSEMENT FOR PANORAMIC OR COMPLETE SERIES X-RAYS REDUCED WHEN PAYMENT HAS
6201	DENTURE RELINES LIMITED TO 1 PER 36 MONTHS	6201	BENEFITS LIMITED TO ONE DENTURE RELINE PER RECIPIENT IN A THIRTY-SIX (36) MON
6202	PALLIATIVE VS OTHER EMERGENCY SERVICES	6202	PALLIATIVE TREATMENT IS NOT REIMBURSED WHEN BILLED BY A PROVIDER ON THE SAME DA
6203	RESERVED FOR FUTURE USE	6203	RESERVED FOR FUTURE USE
6204	PULPOTOMY VS ROOT CANAL THERAPY	6204	A PULPOTOMY IS NOT REIMBURSABLE WHEN PERFORMED ON A TOOTH WHICH PREVIOUSLY HAS
6205	APICOECTOMY VS ORAL SURGERY	6205	APICOECTOMY IS NOT REIMBURSABLE WHEN BILLED BY THE SAME PROVIDER ON THE SAME DA
6206	RESERVED FOR FUTURE USE	6206	PERIODONTAL SCALING IS NOT REIMBURSABLE WHEN PERFORMED ON THE SAME DATE OF SERV
6207	RESERVED FOR FUTURE USE	6207	RESERVED FOR FUTURE USE
6208	OCCLUSAL FILMS LIMITED TO 2 UNITS	6208	INDIANA HEALTH COVERAGE PROGRAM BENEFITS LIMIT OCCLUSAL FILMS TO TWO (2)

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			UNITS
6209	FULL MOUTH OR PANORAMIC X-RAYS LIMITED TO ONCE	6209	FULL MOUTH OR PANOREX X-RAYS ARE LIMITED TO ONCE EVERY THREE YEARS.
6210	PROPHYLAXIS LIMITED TO ONE TREATMENT EVERY SIX	6210	REIMBURSEMENT LIMITED TO ONE TREATMENT OF PROPHYLAXIS EVERY SIX MONTHS FOR NON-
6211	PERIODIC/LIMITED ORAL EVAL LIMIT 1 EVERY 6 MONTHS	6211	PERIODIC OR LIMITED ORAL EVALUATIONS ARE LIMITED TO ONE EVERY 6 MONTHS
6212	FLUORIDE TREATMENT LIMITED TO 1 EVERY 6 MONTHS	6212	INDIANA HEALTH COVERAGE PROGRAM BENEFITS ALLOW PAYMENT FOR ONE TOPICAL APPLICAT
6213	PROSTHODONTIC ADJUSTMENT	6213	DENTURE ADJUSTMENTS ARE NOT PAYABLE WITHIN SIX (6) MONTHS FROM THE FABRICATION
6214	ROOT CANAL PAYABLE AT REDUCED AMOUNT WHEN PULPOTOM	6214	ROOT CANAL PAYABLE AT A REDUCED AMOUNT WHEN PULPOTOMY PAID FOR THE SAME TOOTH O
6215	RESERVED FOR FUTURE USE	6215	RESERVED FOR FUTURE USE
6216	RESERVED FOR FUTURE USE	6216	RESERVED FOR FUTURE USE
6217	GINGIVAL CURETTAGE PAYABLE AT A REDUCED AMOUNT	6217	GINGIVAL CURETTAGE PAYABLE AT A REDUCED AMOUNT WHEN PERIODONTAL SCALING HAS BEE
6218	ONE PULP CAP PER TOOTH PER LIFETIME	6218	INDIANA HEALTH COVERAGE PROGRAM BENEFITS ALLOW REIMBURSEMENT FOR ONE (1) PULP C
6219	PERIODONTAL SCALING AND PLANNING-TWO QUAD. PER DAY	6219	INDIANA HEALTH COVERAGE PROGRAM BENEFITS LIMIT PERIODONTAL SCALING AND PLANNING
6220	REPLACEMENT >THAN 3 TEETH-DENTURES	6220	INDIANA HEALTH COVERAGE PROGRAM

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
	PARTIAL OR COMP		BENEFITS ALLOW REIMBURSEMENT FOR THREE (3) TOOT
6221	PERIODONTAL ROOT PLAN/SCAL 4 TX/2YRS NON-INSTITUTI	6221	REIMBURSEMENT LIMITED TO FOUR TREATMENTS OF PERIODONTAL ROOT PLANING/SCALING EV
6222	PERIODONTAL ROOT PLAN/SCAL 4 TX PER 2 YRS INST	6222	REIMBURSEMENT IS LIMITED TO FOUR TREATMENTS OF PERIODONTAL ROOT PLANING AND SCA
6223	PERIODONTAL ROOT PLANING 4/LIFETIME/>21YR/NON INST	6223	PERIODONTAL ROOT PLANING/SCALING 4X/LIFETIME/NON-INSTITUTIONAL 21 YRS AND OLDER
6224	ONE EXTRACTION PER TOOTH PER LIFETIME	6224	PAYMENT HAS BEEN MADE PREVIOUSLY FOR THE EXTRACTION OF THIS TOOTH.
6225	ONE SEALANT PER TOOTH PER LIFETIME	6225	INDIANA HEALTH COVERAGE PROGRAM BENEFITS ALLOW PAYMENT FOR ONE SEALANT TREATMEN
6226	COMPREHENSIVE/ EXTENSIVE ORAL EVAL LIMIT 1 LIFETIM	6226	COMPREHENSIVE OR DETAILED AND EXTENSIVE ORAL EVALUATIONS ARE LIMITED TO ONE PER
6227	EMERGENCY SERVICES VS PALLIATIVE TREATMENT	6227	SERVICES CONSIDERED EMERGENT ARE PAID AT A REDUCED AMOUNT WHEN PALLIATIVE TREAT
6228	DENTURE RELINE VS DENTURE REPAIR	6228	DENTURE RELINE PAID AT A REDUCED AMOUNT WHEN DENTURE REPAIRS HAVE BEEN REIMBURS
6229	RELINES AND REBASES VS INITIAL DENTURE PLACEMENT	6229	INDIANA HEALTH COVERAGE PROGRAM BENEFITS DO NOT ALLOW PAYMENT OF DENTURE RELINE

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
6234	SUTURING VS. EXTRACTIONS & SURGICAL PROCEDURES	6234	SUTURING IS NOT SEPARATELY REIMBURSABLE WHEN PERFORMED WITH EXTRACTIONS AND OT
6235	PROPHYLAXIS NON-INSTI 21 YRS OR> LIMIT 1/12 MONTHS	6235	PROPHYLAXIS NON-INSTITUTIONAL 21 YEARS OR OLDER LIMITED TO 1 PER 12 MONTHS.
6250	OXYGEN MAXIMUM FEE CUT BACK TO 1 UNIT/28 DAYS	6250	ONE UNIT OF SERVICE IS ALLOWED EVERY 28 DAYS. UNITS OF SERVICE FOR THIS PROCED
6251	UROLOGICAL SUPPLIES(INDWELLING CATHETER) TWO(2)	6251	UROLOGICAL SUPPLIES (INDWELLING CATHETERS) ARE LIMITED TO TWO PER MONTH UNLESS
6252	OXYGEN/POUND VS OXYGEN MAXIMUM FEE REIMBURSEMENT	6252	THE OXYGEN MAXIMUM FEE HAS BEEN PAID FOR THIS RECIPIENT WITHIN THE 28 DAY PERIO
6253	OXYGEN MAX FEE REIMBURSEMENT VS OXYGEN/POUND	6253	LIQUID OR GASEOUS OXYGEN PER POUND HAS BEEN REIMBURSED FOR A DATE OF SERVICE WI
6254	RESERVED FOR FUTURE USE	6254	RESERVED FOR FUTURE USE
6255	TREND EVENT MONITOR COMP NOT REIMB. IN CONJ.W/ TRE	6255	COMPONENTS OF TREND EVENT MONITOR ARE NOT REIMBURSABLE WHEN TREND EVENT MONITOR
6256	TREND EVENT MONITOR EXCEEDS MAXIMUM	6256	TREND EVENT MONITOR IS REIMBURSED A MAXIMUM OF $850.00 PER MONTH AND IS PAYABLE
6256	TREND EVENT MONITOR EXCEEDS MAXIMUM	9256	TREND EVENT MONITOR IS REIMBURSABLE TO A MAXIMUM OF $850.00 PER MONTH, BUT IS N
6257	MAXIMUM REIMBURSEMENT FOR OXIMETRY	6257	MAXIMUM REIMBURSEMENT FOR OXIMETRY IS $280.00 PER RECIPIENT PER 30 DAYS. REIMB
6257	MAXIMUM REIMBURSEMENT FOR OXIMETRY	6753	REIMBURSEMENT IS LIMITED TO ONE

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			OCCUPATIONAL THERAPY EVALUATION PER RECIPIENT P
6257	MAXIMUM REIMBURSEMENT FOR OXIMETRY	9257	MAXIMUM REIMBURSEMENT FOR OXIMETRY IS $280.00 PER 30 DAYS. MAXIMUM REIMBURSEME
6258	INPATIENT PSYCH LEAVE DAYS ONLY ALLOW 60 PER YEAR	6258	THERAPEUTIC LEAVE DAYS ARE LIMITED TO 60 PER CALENDAR YEAR FOR RECIPIENTS RECEI
6260	PAR/ENT KIT OR SUPPLIES DENIED OR PAYMENT REDUCED	6260	PARENTERAL/ENTERAL SUPPLY KITS AND ADDITIONAL SUPPLIES MAY BE BILLED WITHIN THE
6260	PAR/ENT KIT OR SUPPLIES DENIED OR PAYMENT REDUCED	9260	PARENTERAL/ENTERAL FEEDING KIT PAYABLE AT A REDUCED AMOUNT WHEN RELATED SUPPLIE
6261	PARENTERAL/ENTERAL KITS(MAX FEE) VS SUPPLIES	6261	PARENTERAL/ENTERAL SUPPLY KITS AND ADDITIONAL SUPPLIES MAY BE BILLED WITHIN THE
6270	SMOKING CESSATION LIMITED TO 10 UNITS/CALENDAR YR	6270	SMOKING CESSATION COUNSELING SERVICES ARE LIMITED TO 10 UNITS PER RECIPIENT PER
6300	RESERVED FOR FUTURE USE	6300	RESERVED FOR FUTURE USE
6301	RESERVED FOR FUTURE USE	6301	RESERVED FOR FUTURE USE
6350	MORE THAN ONE FQHC - AUTODENY	6350	FQHC SERVICES ARE LIMITED TO ONE PER DAY FOR THE SAME PROVIDER, SAME DIAGNOSIS
6351	MORE THAN ONE FQHC-AUTODENY	6351	MORE THAN ONE FQHC SERVICE IS PAYABLE PER DAY TO THE SAME PROVIDER, FOR THE SAM
6400	JOINT INJECTION-3 PER MONTH WITHOUT PA	6400	JOINT INJECTIONS ARE LIMITED TO THREE PER MONTH. PRIOR AUTHORIZATION IS REQUIR

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
6401	INJECTIONS - ONLY 2 PER MONTH ALLOWED	6401	INJECTIONS ARE LIMITED TO TWO PER MONTH. PRIOR AUTHORIZATION IS REQUIRED FOR A
6402	VITAMIN B12 INJECTION, EVERY 30 DAYS	6402	REIMBURSEMENT FOR VITAMIN B-12 INJECTIONS IS LIMITED TO ONE EVERY 30 DAYS. PRIO
6403	RESPIRATORY MUTUALLY EXCLUSIVE CODES CCI	6403	MUTUALLY EXCLUSIVE SURGICAL PROCEDURE CODE CANNOT BE PERFORMED DURING SAME OPER
6405	COMPONENT NOT PAYABLE WHEN COMPREHENSIVE PAID RESP	6405	COMPONENT PROCEDURE NOT PAYABLE WHEN COMPREHENSIVE PROCEDURE PAID IN HISTORY
6500	OBSOLETE/UNRELIABLE DIAGNOSTIC LABS	6500	RESERVED FOR FUTURE USE.
6501	CLIA HCPCS CODES NOT PAYABLE ON SAME DATE(S) AS CP	6501	THIS IS A DUPLICATE OF A PREVIOUSLY PROCESSED CPT-4 PROCEDURE CODE. PLEASE VER
6502	CLIA CPT EQUIVALENT CODES NOT PAYABLE ON SAME DATE	6502	THIS IS A DUPLICATE OF A PREVIOUSLY PROCESSED HCPCS CODE. PLEASE VERIFY HCPC C
6503	LABORATORY SERVICES OTHER THAN IN HOSPITAL $400.00	6503	RESERVED FOR FUTURE USE.
6504	LAB CHARGE FEE SAME DATE OF SERVICE AS VENIPUNCTUR	6504	THIS SERVICE IS PAYABLE ONLY WHEN PERFORMED IN CONJUNCTION WITH A SCREENING VEN
6506	IN-OFFICE VS SENT OUT LAB PROCEDURES	6506	THIS CLAIM INDICATES THAT LABORATORY PROCEDURES WERE PERFORMED BOTH IN-HOUSE AN
6507	SENT OUT VS IN-OFFICE LAB PROCEDURES	6507	THIS CLAIM INDICATES THAT LABORATORY PROCEDURES WERE PERFORMED BOTH IN-HOUSE

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			AN
6508	SAME DAY DISCHARGE	6508	"SAME DAY DISCHARGE" PLEASE VERIFY DISCHARGE DATE AND RESUBMIT THE CLAIM WITH T
6509	READMISSIONS WITHIN 15 DAYS	6509	RECIPIENT CAN NOT BE READMITTED WITHIN 15 DAYS FOR THE SAME DIAGNOSIS CODE PLEA
6511	ONE DISPENSING FEE PER MONTH FOR LTC RECIPIENTS	6511	ONE DISPENSING FEE PER LTC RECIPIENT PER CALENDAR MONTH.
6514	NOT MORE THAN ONE EMERGENCY ROOM VISIT PER DAY	6514	NOT MORE THAN ONE EMERGENCY ROOM VISIT PER DAY
6600	LENSES INTIAL OR REPLACE-RECIP. 18YRS OR YOUNGER	6600	LENSES INITIAL OR REPLACEMENT- RECIPIENT 18 YEARS OR YOUNGER
6600	LENSES INTIAL OR REPLACE-RECIP. 18YRS OR YOUNGER	9600	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR REC
6600	LENSES INTIAL OR REPLACE-RECIP. 18YRS OR YOUNGER	9900	REIMBURSEMENT LIMITED TO ONE SET OF LENSES PER YEAR FOR RECIPIENTS 18 YEARS OF
6601	FRAMES INITIAL OR REPLACEMENT-RECIPIENT 18 YEARS	6601	FRAMES INITIAL OR REPLACEMENT-RECIPIENT 18 YEARS OR YOUNGER
6601	FRAMES INITIAL OR REPLACEMENT-RECIPIENT 18 YEARS	9600	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR REC
6601	FRAMES INITIAL OR REPLACEMENT-RECIPIENT 18 YEARS	9601	REIMBURSEMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES PER YEAR FOR RE
6602	POST-OP CATARACT LENS REPLACEMENT/ ONE PER YEAR	6602	RESERVED FOR FUTURE USE.
6603	FRAMES INITIAL, REPAIR/REPLACEMENT-	6603	FRAMES INITIAL OR REPLACEMENT-RECIPIENT 19

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
	RECIPIENT OVER		YEARS OR OLDER
6603	FRAMES INITIAL, REPAIR/REPLACEMENT-RECIPIENT OVER	9600	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR REC
6603	FRAMES INITIAL, REPAIR/REPLACEMENT-RECIPIENT OVER	9603	THE DATE OF SERVICE ON THIS CLAIM MATCHES THE RECIPIENT'S SPENDOWN MET DATE FOR
6603	FRAMES INITIAL, REPAIR/REPLACEMENT-RECIPIENT OVER	9903	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF FRAMES EVERY (2) YEARS
6604	LENSES INITIAL OR REPLACE- RECIPIENT OVER 18 YRS	6604	LENSES INITIAL OR REPLACEMENT-RECIPIENT 19 YEARS OR OLDER
6604	LENSES INITIAL OR REPLACE- RECIPIENT OVER 18 YRS	9604	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES EVERY (2) TWO YE
6605	FRAME REPLACE VS FRAME REPAIR ON SAME DATE OF SERV	6605	FRAME REPLACEMENT IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS A FRAME REPAIR
6606	FRAME REPLACEMENT PARTS IN EXCESS OF $20.00	6606	INDIANA HEALTH COVERAGE PROGRAM BENEFITS DO NOT ALLOW PAYMENT OF FRAME REPLACEM
6607	FRAME REPAIR VS FRAME REPLACEMENT	6607	FRAME REPAIR IS NOT PAYABLE ON THE SAME DATE OF SERVICE AS A FRAME REPLACEMENT
6608	FRAMES-ONE(1) REPLACEMENT ALLOWED PER DAY	6608	INDIANA HEALTH COVERAGE PROGRAM ALLOWS PAYMENT FOR ONE (1) FRAME REPLACEMENT PE
6610	ROUTINE VISION EXAM LIMIT TO 1/12 MONTHS AGE 1-18	6610	ROUTINE VISION EXAMS LIMITED TO ONE(1) PER TWELVE (12) MONTHS FOR AGES 1 TO 19
6611	ROUTINE VISION EXAM LIMITED TO 1/24 MONTHS 19-999	6611	ROUTINE VISION EXAM LIMITED TO ONE PER TWENTY-FOUR (24) MONTHS FOR AGES 19 TO 9
6630	PROF/TECH COMP. FOR CARDIAC CATH VS	6630	TECHNICAL AND PROFESSIONAL COMPONENTS

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
	COMPLETE PROCE		NOT PAYABLE WHEN THE COMPLETE PROCEDURE H
6634	COMPLETE PROCED FOR CARD CATH VS TECH/PROF COMPONE	6634	PAYMENT FOR COMPLETE PROCEDURE PAYABLE AT A REDUCED AMOUNT WHEN THE TECHNICAL A
6649	SURGERY PAYABLE AT REDUCED AMOUNT WHEN RELATED POS	6649	REIMBURSEMENT REFLECTS THE DIFFERENCE BETWEEN INDIANA HEALTH COVERAGE PROGRAM'S
6650	LIFETIME PROCEDURES ARE LIMITED TO 1 PER LIFETIME	6650	THE NUMBER OF SERVICE(S) PROVIDED EXCEED MEDICAL POLICY GUIDELINES. THIS IS A
6651	SURGICAL CUTBACK PROCEDURE - 50%	6651	ADDITIONAL SURGICAL PROCEDURE(S) ARE PAYABLE AT 50% OF INDIANA HEALTH COVERAGE
6651	SURGICAL CUTBACK PROCEDURE - 50%	9651	SURGERIES ON THE SAME DATE OF SERVICE, IN THE EXCESS OF TWO, ARE PAID AT 25 PE
6652	RESERVED FOR FUTURE USE	6652	RESERVED FOR FUTURE USE.
6653	POST OP CARE WITHIN 00-90 DAYS OF SURGERY	4005	THE SUBMITTED CHARGE IS MORE THAN FIVE (5) TIMES THE ALLOWED RATE.
6653	POST OP CARE WITHIN 00-90 DAYS OF SURGERY	6653	POSTOPERATIVE MEDICAL VISITS PERFORMED WITHIN 90 DAYS OF SURGERY ARE PAYABLE ON
6654	PRE-OPERATIVE CARE WITHIN 1 DAY OF SURGERY	6654	ROUTINE PREOPERATIVE MEDICAL VISITS PERFORMED WITHIN ONE DAY PRIOR TO SURGERY A
6655	SURGERY PAYABLE AT REDUCED AMOUNT WHEN PRE-OP CARE	4005	THE SUBMITTED CHARGE IS MORE THAN FIVE (5) TIMES THE ALLOWED RATE.

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
6655	SURGERY PAYABLE AT REDUCED AMOUNT WHEN PRE-OP CARE	6655	REIMBURSEMENT REFLECTS THE DIFFERENCE BETWEEN INDIANA HEALTH COVERAGE PROGRAM'S
6656	POST OP CARE WITHIN 10 DAYS OF SELECT SURGERY	6656	POST OPERATIVE MEDICAL VISITS PERFORMED WITHIN 0-10 DAYS OF SURGERY ARE PAYABLE
6657	PRE-OPERATIVE CARE ON DAY OF SURGERY	4005	THE SUBMITTED CHARGE IS MORE THAN FIVE (5) TIMES THE ALLOWED RATE.
6657	PRE-OPERATIVE CARE ON DAY OF SURGERY	6657	ROUTINE PREOPERATIVE MEDICAL VISITS PERFORMED ON THE DAY OF SURGERY ARE NOT SEP
6658	SURGERY PAYABLE AT REDUCED AMOUNT WHEN PRE-OP CARE	6658	REIMBURSEMENT REFLECTS THE DIFFERENCE BETWEEN INDIANA HEALTH COVERAGE PROGRAM'S
6659	SURGERY PAYABLE AT REDUCED AMOUNT WHEN RELATED POS	6659	REIMBURSEMENT REFLECTS THE DIFFERENCE BETWEEN INDIANA HEALTH COVERAGE PROGRAM'S
6660	PRE/POST-OPERATIVE CARE BILLED WITH UNLISTED SURGE	6660	POST-OP MEDICAL VISITS PERFORMED WITHIN THE GLOBAL SURGERY PERIOD ARE PAYABLE O
6661	RESERVED FOR FUTURE USE	6661	RESERVED FOR FUTURE USE
6661	RESERVED FOR FUTURE USE	9661	POS REVERSAL PROCESSING DEFERRED DURING FINANCIAL CYCLE
6664	GLOBAL VS COMPONENTS INTEGUMENTARY/NEUROMUSCULAR	6664	SERVICE PAYABLE AT REDUCED AMOUNT WHEN RELATED COMPONENTS HAVE BEEN PAID FOR TH
6665	BILATERAL VS UNILATERAL SURGERY	6665	SURGICAL PROCEDURE BILLED WITH MODIFIER 50 (BILATERAL) PAYABLE AT A REDUCED AMO

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
6666	RESERVE FOR FUTURE USE	6666	RESERVE FOR FUTURE USE.
6702	NEWBORN SCREENING LIMITED TO ONE PER LIFETIME	6702	NEWBORN SCREENING IS LIMITED TO ONE PER LIFETIME. INDIANA HEALTH COVERAGE PROG
6703	MATERNITY/ONE WITHIN 9 MONTH PERIOD	6703	REIMBURSEMENT FOR MATERNITY CARE LIMITED TO ONE PER PREGNANCY.
6704	FAMILY PLANNING SERVICE/ONE EVERY 12 MONTHS	6704	ONLY ONE FAMILY PLANNING SERVICE ALLOWED WITHIN A 12 MONTH PERIOD.
6705	RESERVED FOR FUTURE USE	6705	RESERVED FOR FUTURE USE.
6706	G.U./REPRODUC. GLOBAL PAY AT REDUC. IF COMP. PAID	6706	URINARY/REPORDUCTIVE SYSTEMS PAYABLE AT REDUCED AMOUNT WHEN RELATED COMPONENTS
6748	HOSPICE RESPITE LIMITED TO FIVE DAYS	6748	HOSPICE RESPITE SERVICES ARE LIMITED TO FIVE DAYS IN A GIVEN PERIOD.
6750	NO MORE THAN 30 HOURS WITHIN 30 DAYS FROM HOSPITAL	6750	NO MORE THAN 30 HOME HEALTH THERAPY HOURS WITHIN 30 DAYS OF HOSPITAL DISCHARGE.
6751	HYPERBARIC OXYGEN THER. GREATER THAN 2 MONTHS	6751	REIMBURSEMENT FOR HYPERBARIC OXYGEN THERAPY FOR MORE THAN TWO MONTHS REQUIRES D
6752	PHYSICAL THERAPY EVALUATION LIMITED TO 1 PER 12 MO	6752	REIMBURSEMENT IS LIMITED TO ONE PHYSICAL THERAPY EVALUATION PER RECIPIENT PER 1
6753	OCCUPATIONAL THERAPY EVALUATION - ONE/12 MONTHS	6753	REIMBURSEMENT IS LIMITED TO ONE OCCUPATIONAL THERAPY EVALUATION PER RECIPIENT P
6754	HYPERBARIC OXYGEN THERAPY	6754	MEDICAL NECESSITY FOR THE USE OF HBO HAS

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
			NOT BEEN ADEQUATELY DOCUMENTED. PLEA
6755	OUTPATIENT THERAPIES EXCEED 80 UNITS PER YEAR	6755	RESERVED FOR FUTURE USE.
6756	DNTL FLUORIDE W/PROPH NOT PAYABLE IF BILLED W/PROP	6756	REIMBURSEMENT IS NOT AVAILABLE FOR PROPHYLAXIS WHEN PAYMENT HAS PREVIOUSLY BEEN
6800	CARE COORDINATION TRANSPORTATION FOR HOME VISITS	6800	INDIANA HEALTH COVERAGE PROGRAM BENEFITS LIMIT TRANSPORTATION FOR HOME VISITS,
6801	CARE COORDINATION-TRANSPORTATION FOR HOME VISITS	6801	REIMBURSEMENT FOR TRANSPORTATION FOR CARE COORDINATION (REASSESSMENT) LIMITED T
6802	CARE COORDINATION-TRANSPORTATION (POSTPARTUM)	6802	REIMBURSEMENT FOR TRANSPORTATION FOR POST PARTUM ASSESSMENT LIMITED TO ONE ROUN
6803	TRANSPORTATION: ONE-WAY TRIP IN EXCESS OF TWENTY	6803	PRIOR AUTHORIZATION REQUIRED FOR TRANSPORTATION SERVICES IN EXCESS OF THE ALLOW
6804	MILEAGE IS NOT PAYABLE WHEN BILLED WITH A TAXI BAS	6804	MILEAGE NOT REIMBURSEABLE WHEN BILLED WITH TAXI-CAB BASE RATE.
6805	REIMBURSEMENT FOR TAXI BASE RATE REDUCED	6805	CLAIM CORRECTED/ADJUSTED TO REFLECT INDIANA HEALTH COVERAGE PROGRAM'S ALLOWABLE
6855	MORE THAN 6 ROUTINE FOOT CARE TREATMENTS PER	6855	REIMBURSEMENT IS LIMITED TO SIX ROUTINE FOOT CARE SERVICES PER YEAR FOR PATIENT

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
6856	RESERVED FOR FUTURE USE	6856	RESERVED FOR FUTURE USE
6857	PREOPERATIVE DOPPLER STUDIES PAYABLE TO PODIATRIST	6857	REIMBURSEMENT FOR NON INVASIVE DOPPLER STUDY IS LIMITED TO ONE PER RECIPIENT PE
6858	EXCESSIVE NURSING HOME VISITS/MORE THAN ONE PER	6858	REIMBURSEMENT LIMITED TO ONE NURSING HOME VISIT PER RECIPIENT PER MONTH. DOCUM
6900	OUTPATIENT MENTAL HEALTH SERVICES MORE THAN 20/YEA	6900	PSYCHIATRIC SERVICES IN EXCESS OF 20 PER YEAR REQUIRE AN APPROVED PRIOR AUTHORI
6901	OUTPATIENT PSYCHIATRIC TESTING EXCEEDS 2 UNITS/YEA	6901	RESERVED FOR FUTURE USE.
6902	OUTPATIENT THERAPIES OVER 80 UNITS REQUIRES PA	6902	PRIOR AUTHORIZATION IS REQUIRED FOR MORE THAN 80 UNITS OF ANY ONE THERAPY OR CO
6903	PCCM LIMITS OFFICE VISITS GREATER THAN 30 VISITS	6903	PRIOR AUTHORIZATION IS REQUIRED FOR MORE THAN 30 OFFICE VISITS FOR RECIPIENTS P
6910	RESERVED FOR FUTURE USE	6910	RESERVED FOR FUTURE USE.
6911	THERAPEUTIC OR DIAGNOSTIC INJECTIONS	6911	INTRA-ARTERIAL, INTRA-VENOUS DIAGNOSTIC, THERAPEUTIC INJECTION SERVICES, AND IN
6915	AUTISM WAIVER DENY > 600 HRS IN A YEAR PER RECIPI	6915	WAIVER SERVICES ARE LIMITED TO 600 HOURS OR 25 DAYS PER YEAR OR 14 CONSECUTIVE
6916	GLOBAL - HOME UTERINE MONITORING	6916	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR COMPONENT PROCEDURES WHEN GLOBAL PR
6917	COMPONENTS-HOME UTERINE MONITORING	6917	SEPARATE REIMBURSEMENT IS NOT AVAILABLE FOR A GLOBAL PROCEDURE WHEN COMPONENT P
6918	DIABETES MANAGEMENT LIMITED TO 16 UNITS	6918	REIMBURSEMENT IS LIMITED TO 16 UNITS OF DIABETES SELF MANAGEMENT TRAINING PER

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
6921	ONE DIAGNOSTIC EVAL PER RECIPIENT EVERY 6 MO	6921	INITIAL DD WAIVER DIAGNOSTIC AND PSYCHIATRIC EVALUATIONS ALLOWED ONCE EVERY SIX
6997	X-RAY NOT PAYABLE WHEN PAID UNDER FULL SERIES	6997	RESERVED FOR FUTURE USE.
6998	STERILIZATION CONSENT FORM IMPROPERLY COMPLETED	6998	RESERVED FOR FUTURE USE.
6999	MFG. INVOICE REQUIRED FOR MANUAL PRICING.	6999	RESERVED FOR FUTURE USE.
7500	BILLING PROVIDER ON PREPAYMENT REVIEW	7500	YOUR CLAIM IS BEING REVIEWED
7501	RECIPIENT LOCKED-IN TO SPECIFIC PRESCRIBING PROVID	7501	YOUR CLAIM IS BEING REVIEWED.
7502	RECIPIENT LOCKED-IN TO SPECIFIC PROVIDER	7502	RECIPIENT LOCKED IN TO A SPECIFIC PROVIDER
7503	RESERVED FOR FUTURE USE	7503	MISSING/INVALID PRODUR CONFLICT CODE. ALERT ON RESPONSE DOES NOT MATCH AN ALER
7504	RESERVED FOR FUTURE USE	7504	MISSING/INVALID PRODUR INTERVENTION CODE. PLEASE USE M0, P0 OR R0 AND RESUBMIT
7508	RESERVED FOR FUTURE USE	7508	RESERVED FOR FUTURE USE.
7509	RENDERING PROVIDER ON PREPAYMENT REVIEW	7509	RENDERING PROVIDER ON PREPAYMENT REVIEW
9002	RESERVED FOR FUTURE USE	9002	ACTUAL ITEMIZED COST INVOICE MUST BE SUBMITTED WHEN BILLING THIS PROCEDURE CODE
9634	RESERVED FOR FUTURE USE	9634	COMPLETE PROCEDURE NOT PAYABLE WHEN THE TECHNICAL AND PROFESSIONAL COMPONENTS H

Table 102.1 –T_ERROR_DISP AND T_EOB

Error Status Code	ESC Description	EOB	EOB Description
9991	REFUND AMOUNT LESS THAN ADJUSTED AMOUNT	8000	PROVIDER REQUESTED FULL OFFSET DUE TO DUPLICATE PAYMENT.
9992	REFUND AMOUNT GREATER THAN ADJUSTED AMOUNT	8000	PROVIDER REQUESTED FULL OFFSET DUE TO DUPLICATE PAYMENT.

Glossary

1115(a)	Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by HCFA. See also *Health Care Financing Administration, PACE, Waiver*.
11971	State form 11971; see *8A*.
1261A	Division of Family and Children State Form 1261A, *Certification - Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*.
1500	This is a claim form used by participating Medicaid providers to bill medical and medically related services.
1902(a)(1)	Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewideness*.
1902(a)(10)	Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver*.
1902(a)(23)	Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver*.
1902(r)(2)	Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.
1903(m)	Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts*.
1915(b)	Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.
1915(c)	Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver*.
1915(c)(7)(b)	Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.

1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care*.
450A	Social Evaluation for Long Term Care Admission.
450B	Certification by Physician for Long Term Care Services.
590 Program	A program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.
7748	State Form 7748, Medicaid Financial Report.
8A	DPW Form 8A State Form 11971, *Notice to Provider of Recipient Deductible.* Used to relay recipient spenddown information to providers.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAP	American Academy of Pediatrics.
ABA	American Banking Association.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.
ACSW	Academy of Certified Social Worker.
ADA	American Dental Association.
ADC	Adult Day Care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.
Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children (AFDC) is replaced with Temporary Assistance for Needy Families (TANF).

AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance recipients, who are 65 years old or older, or recipients under any other category who are entitled to benefits under Medicare.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act.
Aid to the Blind (AB)	A classification or category of recipients eligible for benefits under the Medicaid Program.
AIM	Advanced Information Management.
allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.
Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
auto assignment	Indiana*AIM* process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.

Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning recipient eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.
Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to obtain pertinent information concerning recipient eligibility, benefit limitation, check information, and PA for IHCP participants.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from HCFA regarding persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.
billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP recipient.
billing service	An entity under contract with a provider who prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.

Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of Medicaid services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits/procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP recipients, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal, a document from the Indiana State Department of Health (ISDH) that certifies institutional providers.
C519	Authorization for Recipient Liability Deviation, generated by the Medicaid recipient's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given recipient per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)
case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.
Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.

categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP recipient is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).
CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CDFC	County Division of Family and Children.
CEO	Chief Executive Officer.
certification	A review of CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM recipients to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services; health-care plan for the uniformed services outside the military health-care system, now know as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).
Children's Special Health Care Services(CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: HCFA-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.

claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for Medicaid claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP. See also *Recipient*.
CMHC	Community Mental Health Center.
CMS	Centers for Medicare & Medicaid Services. Effective August 2001, this is the new name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. It was formerly known as the Health Care Financing Administration for HCFA.
co-insurance	The portion of Medicare-determined allowed charge that a Medicare recipient is required to pay for a covered medical service after his/her deductible has been met. The co-insurance or a percentage amount is paid by Medicaid if the recipient is eligible for Medicaid. See also *Cost Sharing*.
Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915(c), Waiver*.
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
concurrent care	Multiple services rendered to the same patient during the same time period.
consent to sterilization	Form used by IHCP recipients certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).

contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
co-payment or co-pay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.
core contractor	Vendor that successfully bids *on Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services*.
COS	Category of Service.
cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.
cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for IHCP using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP recipients.
CP	Clinical psychologist.
CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CPS	Child Protective Services.

CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central processing unit.
CQM	Continuous quality management.
credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.
CRNA	Certified registered nurse anesthetist.
crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to Medicaid benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.
CSHCS	Children's Special Health Care Services. A state-funded program providing assistance to children with chronic health problems. CSHCS recipients do not have to be IHCP-eligible. If they are also eligible for IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
CSW	Clinical social worker.
customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP, including state staff, recipients, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
data element	A specific unit of information having a unique meaning.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
deductible	Fixed amount that a Medicare recipient must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug determined to be less than effective (LTE); not covered by the IHCP.
designee	Duly authorized representative of a person holding a superior position.

detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition.*
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the CMS.
DHS	Department of Health Services.
diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG.*
digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.
direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.
disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples include wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DOS	Date of service; the specific day services were rendered.
down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana agency overseeing agency compliance with all State data processing statutes, policies, and procedures.
DPOC	Data Processing Oversight Commission. Indiana agency providing oversight and review of all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Office of Medicaid Policy and Planning.
DPW Form 8A	See *8A.*
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.

drug code	Code established to identify a particular drug covered by the State Medicaid Program.
Drug Efficacy Study Implementation (DESI)	Listed drugs considered to be less than effective by the U.S. Food and Drug Administration. See also *Notice of Opportunity for Hearing (NOOH)*.
drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series is usually associated with the reference, as well.
DSS	Decision Support System. A data extraction tool used to evaluate Medicaid data, trends, and so forth, for the purpose of making programmatic decisions.
dual eligible	A person enrolled in Medicare and Medicaid.
duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.
EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; primarily seen as LTC, long-term care; also seen as NH or NF.
ECM	Electronic claims management. Claims submitted in electronic format rather than paper. See *ECC*, *EMC*.
ECS	Electronic claims submittal. Claims submitted in electronic format rather than paper. See **ECC, EMC**.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
eligible providers	Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.

eligible recipient	Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See *ECC, ECS*.
EMS	Emergency medical service.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's RA.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to recipients. The EOMB details the payment or denial of claims submitted by providers for services provided to recipients.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's RA.
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for Medicaid-eligible recipients under 21 years old, offering free preventive health care services, such as screenings, well-child visits, and immunizations. If medical problems are discovered, the recipient is referred for further treatment.
error code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.
ESRD	End-stage renal disease.
EST	Eastern Standard Time, which is also Indianapolis local time.
EVS	Eligibility Verification System. System used by providers to verify recipient eligibility using a point-of-sale device, online PC access, or an AVR system.
exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.

FAMIS	Family Assistance Management Information System.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance*.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
fiscal month	Monthly time interval in a fiscal year.
fiscal year	Twelve-month period between settlements of financial accounts.
fiscal year – federal	October 1 - September 30.
fiscal year – Indiana	July 1 - June 30.
flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification - Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*.
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.
FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
freedom of choice	A State must ensure that IHCP beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.

front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the Indiana Medicaid program.
FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.
Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as "paper" and "manual".
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged recipients to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel.
HCFA	Health Care Financing Administration. This is the previous name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. Effective August 2001, it is called the Centers for Medicare & Medicaid Services.
HCFA-1500	HCFA-approved standardized claim form used to bill professional services.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by HCFA. HCPCS includes all subsequent editions and revisions.
header	Identification and summary information at the head (top) of a claim form or report.

HealthWatch	Indiana's preventive care program for Medicaid recipients under 21 years of age. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
help	An online computer function designed to assist users when encountering difficulties entering a screen.
HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.
HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPP	Health insurance premium payments.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management.*
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915(c)(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*

Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound recipients by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.
Hoosier Healthwise	IHCP managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC), and Managed Care for Persons with Disabilities (MCPD).
HPB	Health Professions Bureau.
HRI	Health-related items.
IAC	Indiana Administrative Code. State government agency administrative procedures.
IC	Indiana code.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for Medicaid-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.
IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.

IMCA	Indiana Motor Carrier Authority.
IMD	Institutions for mental disease.
IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.
IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
inquiry	Type of online screen programmed to display rather than enter information. Used to research information about recipients, providers, claims adjustments and cash transactions.
institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPP	Individualized Program Plan.
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health. Currently known as the Indiana State Department of Health (ISDH).
ISDH	Indiana State Department of Health. Previously known as Indiana State Board of Health.

ISETS	Indiana Support Enforcement Tracking System.
ISMA	Indiana State Medical Association.
itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
licensed practical nurse	LPN.
limited license practitioner	LLP.
line item	A single procedure rendered to a recipient. A claim is made up for one or more line items for the same recipient.
LLP	Limited license practitioner.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
location	Location of the claim in the processing cycle such as paid, suspended, or denied.
lock-in	Restriction of a recipient to particular providers, determined as necessary by the State.
lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed practical nurse.
LSL	Lower specification limit, pertains to quality control charts.
LTC	Long term care. Facilities that supply long-term residential care to recipients.
LTE	Less than effective drugs.

M/M	Medicare/Medicaid.
MAC	Maximum allowable charge for drugs as specified by the federal government.
managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MCPD	Managed Care for Persons with Disabilities. One of three delivery systems in the Hoosier Healthwise managed care program. In MCPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
MDS	Minimum data set.
Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a recipient's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency.*
Medicaid State plan	See also *Single State Agency, Medicaid Plan.*

Medicaid-Medicare eligible	Recipient who is eligible for benefits under both Medicaid and Medicare. Recipients in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.
medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.
Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A and/or Part B for services authorized by Medicare Part A and/or Part B.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.*
mental retardation	Significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.
menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.

MFCU	Medicaid Fraud Control Unit.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral
misutilization	Any usage of the IHCP by any of its providers or recipients not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
MLOS	Mean Length of Stay.
MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.
MMIS	Medicaid Management Information System. Indiana's current MMIS is Indiana*AIM*.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team. FSSA Unit that makes decisions regarding disability determination.
MSW	Master of Social Work.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NEC	Not elsewhere classified.
NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to online, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility.

NH	Nursing home.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver.*
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI).*
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act. Federal laws that direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.
OMNI	Point-of-sale device used by providers to scan recipient ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter (in reference to drugs).
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs Medicaid functions under the direction of the single state agency. The single state agency may perform all Medicaid functions itself or it may delegate certain functions to other processing agencies.

outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a Medicaid recipient from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a Medicaid recipient resulting from the failure of the contractor to use available information or to process correctly.
override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.
PA	Prior authorization. Some designated Medicaid services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by Medicaid.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by Medicaid that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.

Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary*.
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In*.
participant	One who participates in the IHCP as either a provider or a recipient of services.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participating recipients	Individuals who receive Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve Medicaid recipients and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a recipient's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term-care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Primary care case management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Recipients are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the recipient and providing all primary care and authorizing specialty care for the recipient—24 hours a day, seven days a week.
PCN	Primary care network.
PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.

peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device that enables the consumer to secure help in an emergency.
personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PGA	Peer group average.
PHC	Primary home care. Medicaid-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA*.
physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
plan of care	A formal plan developed to address the specific needs of an individual; links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to Medicaid recipients assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.

PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO).*
PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.
prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities needed to meet all federal Pro-DUR requirements and all DUR requirements.

profile	Total view of an individual provider's charges or a total view of services rendered to a recipient.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that provides a covered IHCP service to an IHCP recipient.
provider enrollment application	Required document for all providers who provide services to IHCP recipients.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.
provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor, dentist.
PSRO	Professional standards review organization.
purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.

QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBA	Room and board assistance.
RBMC	Risk-based managed care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. The delivery system serves TANF recipients, pregnant women, and children.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by OMPP.
reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
recipient	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP recipients. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Recipient*.
recipient relations	The activity within the single state agency that handles all relationships between the IHCP and individual recipients.
recipient restriction	A limitation or review status placed on a recipient that limits or controls access to the IHCP to a greater extent than for other nonrestricted recipients.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a recipient to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.

reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance*.
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the recipient disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.
rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.
repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Restrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic.
RID	Recipient identification (ID) number; the unique number assigned to an individual who is eligible for Medical Assistance Programs services.

risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool.*
RN	Registered nurse.
RNC	Registered nurse clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment
RPT	Registered physical therapist.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
SBOH	State Board of Health. Previous term for the State Department of Health.
screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.
service date	Actual date on which a service(s) was rendered to a particular recipient by a particular provider.
service limits	Maximum number of service units to which a recipient is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with an MCO's health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.

SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Omnibus Budget Reconciliation Act of 1986.
SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.
specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
spenddown	Process whereby Medicaid eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.
SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.

SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.
State	The state of Indiana and any of its departments, agencies, and public agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.
State Medicaid Office	Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the Medicaid program in Indiana.
State Plan	The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.
status	Condition of a claim at a given time; such as paid, pended, denied, and so forth.
stop-loss insurance	Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125% of the amount expected in an average year. See also *Reinsurance*.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.
submission	The act of a provider sending billings to EDS for payment.
subsystem	A Medicaid term that refers to one of the following (I)HIS processing components: recipient's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.

| SUR | Surveillance and Utilization Review. Refers to system functions and activities mandated by the CMS that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements: |

. statistical analysis

. exception processing

. provider and recipient profiles

. retrospective detection of claims processing edit/audit failures/errors

. retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards

. retrospective detection of fraud and abuse by providers or recipients

. sophisticated data and claim analysis including sampling and reporting

. general access and processing features

. general reports and output

| suspended transaction | A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s). |

| suspense file | Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s). |

| systems analyst/engineer | Responsible for performing the following activities: |

0. Detailed system/program design

1. System/program development

2. Maintenance and modification analysis/resolution

3. User needs analysis

4. User training support

5. Development of personal Medicaid program knowledge

| TANF | Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children. |

| TEFRA | Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program. |

| TEFRA 134(a) | Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children. |

| therapeutic classification | Code assigned to a group of drugs that possess similar therapeutic qualities. |

| third party | An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or recipient of, medical assistance under Title XIX. |

third-party resource	A resource available, other than from the department, to an eligible recipient for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.
Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all recipients to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirments of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the recipients to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services*.

TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
UPC	Universal product code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization review.
UR	Utilization Review. A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VFC	Vaccines for Children program.
VFC	Vaccine for Children program.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under 5 years old.

workmen's compensation   A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.